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DEATH ANXIETY AND FEAR OF DEATH ATTITUDES:
A DEATH EDUCATION PROGRAM FOR STUDENT NURSES

by

M. Terrance Lally

A Dissertation Submitted to the Faculty of the
Graduate School of Loyola University of Chicago
in partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy

May
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VITA

The author, Martin Terrance Lally, is the son of Martin Lally and Nellie (Coan) Lally. He was born October 15, 1939, in Chicago, Illinois.

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CHAPTER I

INTRODUCTION

Background of the Study

Numerous authors have documented the considerable stress experienced by nurses when encountering the dying patient and have indicated the need for death education programs to further assist students in reducing their death anxiety and fear of death attitudes (Bailey, 1976; Benoliel, 1982; Birch, 1979; Castronovo, 1978; Denton & Wisenbaker, 1977; Fairchild, 1977; Fulton & Langton, 1964; Golub, 1971; Hopping, 1977; Mandel, 1981; Price & Bergen, 1977; Vanden Berge, 1966; Yeaworth, Kapp, & Winget, 1974).

Research evaluating the effectiveness of death education programs has been contradictory. Some studies support the effectiveness of death education, others do not, and still others have found that death education increased death anxiety and fear of death attitudes (Bohart & Bergland, 1979; Combs, 1981; Hopping, 1977; Kasmarick, 1974; Miles, 1980). Further research effort may help to determine just what kinds of programs may be most effective in assisting student nurses.

In the present study the author developed a death education program and then evaluated its effectiveness in

decreasing junior and senior baccalaureate nursing students' death anxiety and fear of death attitudes. In accordance with Corr's (1978) recommendations, audio-visual aids were utilized to facilitate small group discussions which focused on concerns about death. In order to determine if clinical experience was a necessary component of the program, the responses of the junior and senior nursing students to the death education program were compared. The seniors in this study had had clinical experience with dying patients, but the juniors had not.

The nonreligious appear to fear death less than the minimally religious, but experience a greater fear of death than persons of strong religious convictions (Hinton, 1972). Therefore, it was the intent of this study to determine if the ultimate values type of the students influenced the effectiveness of the death education program. The concept of ultimate values type was developed by McCready and Greeley (1976) as a preferable method for determining religious values and how they impact on concerns about death.

Unlike the majority of studies evaluating the effectiveness of death education programs, this study utilized a multidimensional conception of death attitudes instead of a unidimensional conception. The Hoelter (1979) Multidimensional Fear of Death Scale was used to measure varying positive and negative perspectives on the dying process, the dead, being destroyed, significant others, the unknown,

conscious death, the body after death, and premature death. It is hoped that this approach would more accurately reflect the complexity of each student nurse's attitudes toward death.

Statement of the Problem

The specific research questions which were of concern in this study are as follows:

1. Would a death education program decrease death anxiety experienced by baccalaureate nursing students?
2. Does the level of the baccalaureate nursing student, junior or senior, influence the effectiveness of the death education program in reducing death anxiety?
3. Would a death education program reduce baccalaureate nursing students' fear of death attitudes, namely fear of dying, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death?
4. Does the level of the baccalaureate nursing student, junior or senior, influence the effectiveness of the death education program in reducing fear of death attitudes?

5. Does the ultimate values type of the baccalaureate nursing student, diffuse, secular optimist, religious optimist, hopeful or pessimist, influence the effectiveness of the death education program in reducing death anxiety and fear of death attitudes?

Significance of the Problem

While student nurses will encounter death and dying throughout their careers, they, like other medical personnel, often have a difficult time coping with the stress of caring for the dying. Birch (1979) found that feelings of personal inadequacy, lack of clinical experience, and the difficulty of caring for the dying are productive of major anxiety for the student nurse. Nurses have criticized their educational programs as inadequate in preparing them to support and comfort the dying patient (Hogart and Spilka, 1978-79). As a result of the anxiety produced by dying patients, students and staff nurses tend to avoid the pain by controlling feelings and developing professional detachment that helps them withdraw emotionally from patients (Miles, 1980).

Birch (1979), Epstein (1975), Mandel (1981), Miles (1980), Quint (1967), Schoenberg (1969), and Watson (1968) have urged that educational courses for student nurses be provided in order to assist them in dealing with personal feelings about death. Despite this perceived need, Thrush,

Paulus, and Thrush (1979) found that of 205 randomly sampled nursing schools only 5% reported offering a required death and dying course. Student nurses do need a death education course or module to help them deal with their complex feelings surrounding death. There have been previous studies indicating the effectiveness of death education with staff and nurses (Bailey, 1976; Bell, 1975; Castronovo, 1978; Durlak, 1978; Kasmarik, 1974; Lester, Getty, & Kneisel, 1974; Leviton & Fretz, 1978; McDonald, 1981; Miles, 1980; Murray, 1974; Pine, 1977; Redick, 1974; Ross, 1978; Watts, 1977; Yeaworth, Kapp, & Winget, 1974). A few researchers, however, have reported little or mixed success with such programs (Bohart & Bergland, 1979; Denton & Wisenbaker, 1977; Hopping, 1977). Still other researchers have unexpectedly noted a significant increase in death anxiety and fear of death attitudes as a result of death education (Epley, Hoelter, & McCaghy, 1977; Mueller, 1976; Combs, 1981; Wittmair, 1979-80). In view of these research findings, to be reviewed in Chapter II, no general conclusions can be drawn concerning the effects of death education, but the continuing need for programs designed to help student nurses examine and share their own feelings and reactions to grief and death is evident.

Most research concerned with the effectiveness of death education has not made a clear distinction between the cognitive dimension, fear of death attitudes, and the affec-

tive dimension, death anxiety. It was the intent of this study to focus on both of these dimensions. Death anxiety was measured by the State Anxiety Scale which was administered after the students had viewed a film depicting a death experience. Fear of death attitudes was measured by the Hoelter (1979) Multidimensional Fear of Death Scale. Unlike the majority of studies evaluating the effectiveness of death education programs, this study utilized a multidimensional scale to measure death attitudes instead of a unidimensional scale. Researchers such as Durlak and Kass (1982), Minton and Spilka (1972), and Schultz (1978) have contended that death attitudes should be treated in multidimensional terms in order to take into consideration varying positive and negative perspectives on death and dying.

Previous research indicates the possibility that clinical experience with dying patients and religious values might influence the effectiveness of a death education program. Yeaworth, Kapp, and Winget (1974) and Goodell, Donohue, and Benoliel (1982) have indicated the importance of clinical experiences in death education. Juniors in this study did not have supervised clinical experience with dying patients while seniors did have such an experience. As to religious values, there appears to be a relationship between religiosity, death anxiety and fear of death attitudes. However, rather than viewing religiosity from the perspective of dogma, doctrine, devotion or ritual as has been done

in previous research, McCready and Greeley (1976) recommend that religion be defined as an individual's perception or interpretation of ultimate reality, since the focus is on values rather than whether people are more or less religious.

Purpose of the Study

The purpose of this study was to evaluate a death education program developed by the author. Two other considerations of this study were to investigate whether or not clinical experience with dying patients and the ultimate values type of the student nurse had any influence on the effectiveness of the death education program in altering fear of death attitudes and death anxiety.

Definition of Terms

For the purpose of clarity, the dependent and independent variables are defined as they pertain to the study. It should be noted that the dependent variables are defined according to the descriptions given by the authors of the instruments used in the study.

Death Anxiety

"Anxiety is a transitory emotional state or condition of the human organism that is characterized by subjective, consciously perceived feelings of tension and apprehension, and heightened autonomic nervous system activity" (Spielberger, Gorsuch, & Lushene, 1970). Death anxiety is

such an emotional state in response to explicit death experience. Level of death anxiety is operationally defined as scores on the State Anxiety Scale, which is administered after subjects view a film depicting a death experience.

Fear of Death Attitudes

"Fear of death attitudes are viewed as subjective feelings of unpleasantness and concern based on contemplation or anticipation of fear of dying, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death" (Hoelter, 1979). Level of fear of death attitudes is operationally defined as scores on the Multidimensional Fear of Death Scale.

Fear of Dying

"Fear of dying deals with the specific act of dying rather than with any related consequences accompanying death."

Fear of the Dead

"Fear of the dead pertains to people or animals that have died."

Fear of Being Destroyed

"Fear of being destroyed deals with destruction of one's body immediately following death."

Fear for Significant Others

"Fear for significant others relates to fear of

significant others dying as well as fear associated with the effects one's death may have on significant others."

Fear of the Unknown

"Fear of the unknown deals with the ambiguity of death and the ultimate question of existence."

Fear of Conscious Death

"Fear of conscious death deals with living out horrors associated with the immediate processes subsequent to death whereby the pronouncement of death is not accepted to be the final termination of consciousness."

Fear for the Body After Death

"Fear for the body after death is associated with concern for bodily qualities after death."

Fear of Premature Death

"Fear of premature death is based on the temporal element of life and concerns the failure to achieve goals and experiences."

Ultimate Values Type

"An ultimate values type is one of five possible interpretative responses for dealing with the most complex of human problems such as suffering and death" (McCready & Greeley, 1976). The five ultimate values types, secular optimist, religious optimist, hopeful, pessimist, and diffuse, are derived from responses in the Ultimate Values Typology questionnaire.

Secular Optimist

"The secular optimist type believes that all events in life, both sad and happy, ultimately turn out for the best and that we must all be thankful for the good things in life."

Religious Optimist

"The religious optimist type believes that reality is ultimately good, though tinged with some sadness and evil which are not of major moment."

Hopeful

"The hopeful type believes that there is great evil in the world and we cannot deny this, but evil has not totally won out, the last word has not yet been spoken."

Pessimist

"The pessimist type believes that we live in an unjust and unfair world, suffering is everywhere and there is little we can do about it."

Diffuse

"The diffuse type exhibits some or all of the characteristics of the four preceding types but does not clearly fall into any single type."

Level of Student

Level of student refers to whether the student is in the junior or senior year in the nursing program.

Death Education Program

The death education program consists of five ses-

sions utilizing audio-visual experiences of death followed by small group guided discussion. The program is aimed at fostering positive attitudes toward death and decreasing death anxiety.

Basic Assumptions of the Study

Procedures in this study are based upon the following assumptions:

1. The State Anxiety Scale provides a measure of death anxiety when administered after the viewing of a film depicting a death experience.
2. The Multidimensional Fear of Death Scale provides a measure of fear of death attitudes.
3. The level of death anxiety and fear of death attitudes, as assessed by the State Anxiety Scale and the Multidimensional Fear of Death Scale, provides a measure of effectiveness of the death education program.
4. The Ultimate Values Typology provides a measure of religiosity.
5. Subjects will follow directions requesting that they not discuss the study prior to the completion of the death education program.

Procedure

The subjects who participated in this study were 22

junior and 32 senior baccalaureate nursing students at a private sectarian liberal arts college. Students were randomly assigned to either the experimental or control group. Both of these groups convened together in order to view the film, The Day Grandpa Died. Following the film all the subjects were asked to complete the State Anxiety Scale, the Multidimensional Fear of Death Scale, and the Ultimate Values Typology.

The experimental group was randomly divided into smaller groups which continued to meet 1 hour a week for 5 sessions. Each session consisted of an audio-visual presentation followed by guided group discussion. In the first session, a filmstrip and audio-cassette, Gramp: A Man Ages and Dies, was shown after the students had the opportunity to read a brief introduction to the filmstrip. At the second session, Dr. Vincent Hunt described on the audio-cassette, Facing Death with the Patient: An On-Going Contract, his own experiences in caring for dying patients, the general principles he had found effective, and the ongoing contract he formed with the patient to insure the best possible care. In addition to Dr. Hunt's presentation, the first part of a taped interview with Ms. McArdle, head nurse of a hospice program, was played for the students. Ms. McArdle discussed attitudes about death, experiences with dying patients, and the nurse's role in caring for the dying. In the third session, the last 40 minutes of the

taped interview with Ms. McArdle was presented. The fourth session featured the film, Death; and at the fifth session an audio-cassette, Conversations with a Dying Friend, was played.

At the completion of the death education program, subjects in both the experimental and control groups met again for 30 minutes. The film, Soon There Will Be No More Me, was viewed. Following the film, the State Anxiety Scale and the Multidimensional Fear of Death Scale were again administered to all the subjects.

Limitations of the Study

The major limitations of this study are as follows:

1. The results of this study cannot be generalized to all nursing students, since the subjects in this investigation were female, junior and senior baccalaureate nursing students at a small, private sectarian liberal arts college. The experiment would have to be replicated in a number of representative schools of nursing in order to control for the interaction effects of selection biases and the experimental variable.
2. Control of extraneous variables presents a problem in field experiments. In an attempt to control such variables, subjects were randomly assigned to either the experimental or control group, and sex was held constant.

3. Reactive effects of experimental procedures may have presented a problem in that subjects knew that they were in an experiment and might have reacted with unusual effort or cooperation.
4. The experimenter bias effect may have occurred in that the researcher might have inadvertently interacted with subjects to alter their expectations and motivations to fit his preconceptions. Due to financial and time constraints, the author had to function as experimenter.
5. Minimizing error variance is a problem in field experiments due to lack of measurement precision. Every attempt was made to choose reliable measures of the variables and the measurement conditions were as controlled as possible.
6. Pretesting might have sensitized subjects so that they responded to the treatment differently than if no pretesting had taken place. The randomized Solomon four-group design, which would eliminate this problem, could not be used due to the limited number of available subjects.
7. The small sample size made it impossible to analyze data concerning the Ultimate Values Typology.

Organization of the Study

Chapter I presented an overview of the study and included a discussion of the background of the study, statement of the problem, significance of the problem, purpose of the study, definition of terms, basic assumptions of the study, procedure, and limitations of the study. Chapter II contains a review of relevant research focusing on death anxiety; fear of death attitudes; the relationship between religiosity, death anxiety and fear of death attitudes; and death education programs. The hypotheses are listed at the close of this chapter. Chapter III presents the methodology used in the study and includes a discussion of the subjects, procedure, instrumentation, and design and statistical analysis. Chapter IV includes the statistical findings of the study and a discussion of the results, and Chapter V presents a summary of the study, as well as implications and recommendations for further research.

CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature will focus on four areas: death anxiety; fear of death attitudes; religiosity, death anxiety and fear of death attitudes; and death education programs.

Death Anxiety

If it is less true than in the past that the Western world tends to fear and deny death and anything related to it, it is because there has been much popular acclaim accorded to Becker (1973), Kubler-Ross (1969), and Mitford (1963), who have written well and knowingly about this most difficult of topics. Many of us will die in hospitals, and medical personnel are certainly far better prepared to help us deal with our own or beloved others' deaths than at any time in the past.

Nurses are often the most immediate carers for dying patients and their families, and some researchers indicate that nurses' relationships to dying patients can have a great influence on how the patient and family cope with this most inevitable of happenings (Fulton & Langton, 1964; Golub, 1971). It is certainly the case that major impli-

cations for nursing action can be determined by an attentive, empathetic, concerned nurse willing to talk with dying patients about their diagnoses, death, and attitudes toward dying (Simmons, 1972).

In spite of the fact that death education has been included in the curriculums of many nursing programs, nurses caring for dying patients experience stress (Folta, 1965; Miles, 1980). Birch (1979) found that student nurses reported a great amount of difficulty with death. He concluded that behavioral aspects of caring for the dying are productive of major anxiety, and the nurse's perception of her own aging and dying process is in itself a potential barrier to her delivery of adequate health care.

Nurses working on oncology and intensive care units seem to have difficulty in establishing a meaningful relationship to death. Baker and Lynn (1979) discovered that nurses on oncology wards experienced considerable anxiety, depression, and hostility in working with dying patients; and Huckaby and Jagla (1979) noted that nurses on an intensive care unit found the death of a patient to be very stressful. Staff in a newly opened palliative care unit experienced only slightly less stress than a group of newly widowed women. Nurses were found to focus on problems with dying patients as a displacement for their feelings of personal inadequacy in dealing with stressful situations (Vachon, Lyall, & Freeman, 1978). Price and Bergen (1977)

feel that the stress experienced by nurses is due to an unconscious confusion between the feeling of being responsible for the care of an ill or dying patient and the feeling of being responsible for the occurrence of the patient's illness or death.

It is not just on oncology and intensive care units that strong emotions are experienced in death's wake. Friedman, Franciosi, and Drake (1979) described an observed case of Sudden Infant Death Syndrome in which hospital staff, who attended a baby during his admission, experienced the same traumatic reactions as families of SIDS victims, namely shock, disbelief, anger, guilt, fear, blaming, sadness, and behavioral manifestations. The unique aspects of SIDS, lack of etiology and its sudden and unexpected onset, brought forth personal feelings of vulnerability. Information on SIDS, communication about feelings, and continued group support were of utmost importance in helping the staff to deal with the crisis.

The negative or difficult aspects of working with the dying are usually expressed through professional detachment and withdrawal, acting tired at work, being sick, or through voicing grievances against the institutions in which the nurses work (Fairchild, 1977; Hurley, 1977; Mandel, 1981; Menzies, 1960; Quint, 1969; Schoenberg, 1969; Schultz & Aderman, 1976; Sobel, 1969). There are many possible reasons for this behavior. Schultz and Aderman (1976)

suggest that nurses associate dying patients with failure and disappointment, and therefore tend to cope with death by avoiding it. Sobel (1969) found that nurses on a coronary care unit often supported the patient's denial to protect themselves from being exposed to the patient's feelings of anger, bitterness, helplessness, sorrow, and hopelessness. According to Mandel (1981), the patient's hopeless circumstances and their physical needs and demands, for which the nurses are almost solely responsible on a minute by minute basis, generate a tremendous amount of anger and guilt on the part of staff. A high degree of anxiety results from seeing a patient gradually lose control of his/her life. Inextricably connected with this anxiety is the nurse's concern over identifying too strongly with the dying patient and his/her family, of seeing herself at some future time in the same situation. Frustration and confusion are created by the lack of skills and power to deal with physical demands and psychological needs of patients. There is also a feeling of being overwhelmed by the intensity, magnitude, and scope of the problems encountered in working with the dying patient. Nurses feel torn over just how much support they can give to the patient without jeopardizing their professional job requirements and their own emotional health.

Because of the extensive physical, emotional, and spiritual demands made on nurses caring for terminally ill

and dying patients, Roach (1978) believes that not all nurses who desire to care for dying patients necessarily have the capacity to do so, but those who do require the acceptance and support of a caring community within the hospital. Vachon (1979) has suggested that staff often choose to work with the dying for one of six reasons: accident or convenience, a desire to do the "in" or popular thing or to affiliate with a charismatic leader, intellectual appeal and a desire for mastery over pain and death, a sense of "calling", previous personal experience, and a suspicion that one might someday develop a terminal disease. Nurses may view hospital deaths as reminders of their own mortality, and contacts with dying patients as vicarious rehearsals for their own dying process and that of persons close to them (Vanden Berge, 1966; Weissman, 1972). Each of these motivations for working with the dying may lead to its own particular forms of stress. In addition, constant exposure to the dying can effect one's personal life and relationships with family members and friends. Epstein (1975) has aptly concluded that when the dying patient and the nurse come together, it is not unusual for the professional to be more in need of help than the patient.

Mandel (1981) believes that there is little awareness of the psychological impact that working with the chronically and terminally ill can have on a nursing staff. At least little is being done to help relieve the tension

that can result. Hoggatt and Spilka (1978-1979) reported that 79.4% of the nurses in their study felt that the nursing profession placed more emphasis on the preservation of life than on palliative and symptomatic care of the dying, and 61.5% claimed that their education was inadequate in preparing them to support and comfort the dying patient. In agreement with this finding, Popoff and Funkhouser (1975) noted that the majority of nurses in their study felt confident in providing technical care to the dying patient, but 42% indicated a lack of confidence in giving psychological care. It seems certain that working with the dying and terminally ill promotes unique forms of anxiety for beginning staff nurses and student nurses who feel ill-prepared to handle the situation. The need for effective death education programs in nursing curriculums is evident.

In summary, it is logical to argue that anxiety on the part of the student nurse may reduce his or her ability to care for the dying patient. Numerous authors document the considerable stress experienced by nurses on intensive care and oncology wards of the hospital, as well as the strong emotions sometimes experienced when sudden death is encountered. The many varied emotions and needs of the patient are not easily met by nurses who may be technically well trained, but feel overwhelmed by the many divergent demands made on them. Many nurses have indicated the need for nursing education to assist students in reducing their

death anxiety so that they are better able to support and comfort the dying.

Fear of Death Attitudes

When asked to list their attitudes towards their own death and the deaths of significant others in their lives, Mandel (1981) found that nurses hoped that they themselves and their loved ones would die without suffering. They identified death in the hospital as a painful death and wished to be spared that experience. The nurses hoped to live a full life, to accomplish their major aims, and not to have to die alone. They felt anger, frustration, and desperation about facing their own deaths before living out their lives fully. In thinking about their own death, many nurses also expressed a fear of losing control and power, fear of the unknown, and a sense of helplessness. Major concerns and thoughts were expressed about those that would be left behind should death occur, and confusion was felt about why they or others had to die.

It is not difficult to see that the individual nurse's attitudes toward death can be very complex given her own unique personality, personal acquaintanceship with death in her family and among friends, and previous professional experiences in caring for the dying. That is why it is somewhat surprising that previous studies concerned with death attitudes have tended to define fear of death as a distinct, homogenous, and unidimensional entity. More

recently some researchers, Durlak and Kass (1982), Minton and Spilka (1972), and Schulz (1978), have contended that a more fruitful approach would treat death attitudes in multidimensional terms which would take into consideration varying positive and negative perspectives on death and dying. In addition, Dickstein (1972) has criticized existing unidimensional measures for meager information or construct validity and frequent lack of reliability data, particularly that of test-retest and internal consistency.

Hoelter (1979) has developed a reliable scale for the measurement of fear of death attitudes, which is based on a multidimensional conception of fear of death. In developing the Multidimensional Fear of Death Scale, Hoelter included dimensions explicitly hypothesized in the earlier work of Collett and Lester (1969), Diggory and Rothman (1961), Kalish (1963), and Nelson and Nelson (1975). He defined fear of death as "an emotional reaction involving subjective feelings or unpleasantness and concern based on contemplation or anticipation of any of eight facets related to death." These eight facets are fear of the dying process, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death. Fear of the dying process deals with the specific act of dying, rather than with any related consequences accompanying death. Fear of the dead pertains to people or

animals that have died. Fear of being destroyed deals with human destruction of one's body immediately following death. Fear for significant others relates to fear of significant others dying, as well as fear associated with the effects one's death may have on significant others. Fear of the unknown deals with the ambiguity of death and the ultimate question of existence. Fear of conscious death deals with living out horrors associated with the immediate processes subsequent to death whereby the pronouncement of death is not accepted to be the final termination of consciousness. Fear for the body after death is associated with concern for bodily qualities after death. Fear of premature death is based on the temporal element of life and concerns the failure to achieve goals and experiences before death. In this study, Hoelter's Multidimensional Fear of Death Scale was utilized to assess the effectiveness of a death education program in reducing the fear of death attitudes of junior and senior baccalaureate nursing students.

In summary, nurses have expressed complex attitudes toward death. They have indicated concerns about suffering, pain, a shortened life, unfulfilled goals, loss of control or power over their life, and fear for those that would be left behind should they die.

Given the complexity of each person's attitudes toward death, researchers have urged that death attitudes be treated in multidimensional terms which would take into

consideration varying positive and negative perspectives on death and dying. Hoelter (1979) has developed a reliable scale for the measurement of fear of death attitudes, which is based on a multidimensional conception of fear of death. He defined fear of death as "an emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation or anticipation of any of eight facets related to death." These eight facets are fear of the dying process, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death. In this study, Hoelter's Multidimensional Fear of Death Scale was utilized to assess the effectiveness of a death education program in reducing the fear of death attitudes of junior and senior baccalaureate nursing students.

Religiosity, Death Anxiety and Fear of Death Attitudes

Previous research examining the relationship between religiosity, death anxiety and fear of death attitudes has been contradictory. Most studies have not detected an association (Alexander & Adlerstein, 1959; Christ, 1961; Edmunds, 1981; Eichman, 1974; Kalish, 1963b; Lester, 1970; Ray & Najman, 1974; Seigman, 1961; Swain, 1975; Templer, 1972; and Templer & Datson, 1970). Other studies have found an inverse relationship. Patrick (1979) found that Christian groups reported less death anxiety and significantly more positive attitudes about death than Buddhists. Several

other researchers noted that the religiously active and those with fundamental religious beliefs had less death anxiety and fewer fear of death attitudes than those not involved in religious activities or those with less fundamental beliefs (Cerny, 1977; Clark, 1978; Kalish, 1963a; Martin & Wrightman, 1965; Swenson, 1961). Reading the bible and the belief in afterlife were found to be negatively related to death anxiety and fear of death attitudes (Jeffers, Nichols, & Eisdorfer, 1961; Osarchuk & Tatz, 1973).

A positive relationship between religiosity, death anxiety and attitudes toward death has also been found. Founce and Fulton (1958) pointed out that spiritually oriented persons experienced greater death anxiety than those not so oriented. Similarly, Feifel (1959) found that religious persons reported more fear of death attitudes than nonreligious persons and, in a later study, Feifel and Heller (1962) suggested that religion is chosen by those experiencing above-average death anxiety.

The discrepancies in research findings could be due to the relationship that appears to exist between extrinsic and intrinsic religiosity, death anxiety and fear of death attitudes. Examining terminally ill patients in England, Hinton (1972) found that the nonreligious feared death less than persons minimally or extrinsically religious, and had more fear of death than persons of strong religious convic-

tion who are intrinsically religious. An extrinsic religious orientation refers to religious devotion that is a means of obtaining goals such as personal comfort, security, and social status. Whereas, intrinsic orientation refers to faith that transcends self-centered needs and arises from a deep personal commitment (Allport, 1959). Like Hinton, Kahoe and Dunn (1975) and Cremins (1971) found a negative relationship between intrinsic religiosity and fear of death, but no relationship between extrinsic religiosity and fear of death. Spilka, Stout, Minton, and Sizemore (1977) found that intrinsic religiosity related negatively to several perceptions of death, namely loneliness and pain, indifference, the unknown, and the future, while it related positively to an afterlife of reward. Extrinsic religiosity was related positively to the death perspectives of loneliness and pain, indifference, forsaking dependents, failure, and natural end.

Burrows (1971) attempted to demonstrate that it is not religiosity per se but comfort with his/her religious beliefs that determines a person's anxiety about death and attitudes toward death. It was predicted and confirmed that those subjects not comfortable with their religious position had higher death anxiety and more negative attitudes toward death both before and after viewing slides of corpses.

McCready and Greeley (1976) feel that religion is not limited to dogma, doctrine, devotion or ritual, but

rather it is a set of cultural convictions concerning the individual's perception of transcendent reality. Basic beliefs or ultimate values are man's way of struggling with ultimate questions of the meaning and purpose of life which are raised by his own death. The evidence of mortality is present to everyone, and we are driven to determine if transcendent reality is malicious, benign, or neutral. McCready and Greeley believe that a religion, and especially the symbols associated with it, is "ultimate" in the sense that it provides both a conviction that reality is interpretable and a model for dealing with the most complex human problems such as death, suffering, and the experience of limitations.

McCready and Greeley proposed that there are five major ultimate value responses among modern Americans. The secular optimist type believes that all events in life, both sad and happy, ultimately turn out for the best; and that we all must be thankful for the good things in life. The religious optimist type believes that reality is ultimately good, though tinged with some sadness and evil which are not of major moment. The hopeful type believes that there is great evil in the world and we cannot deny this, but evil has not totally won out, the last word has not yet been spoken. The pessimist type believes that we live in an unjust and unfair world, suffering is everywhere and there is little we can do about it. The diffuse type exhibits

some or all of the characteristics of the four preceding types but does not clearly fall into any single type.

In summary, research examining the relationship between religiosity, death anxiety and fear of death attitudes has been contradictory. The discrepancies in research findings could be due to the fact that the nonreligious appear to fear death less than the minimally or extrinsically religious, but they experience a greater fear of death than persons of strong religious convictions who are intrinsically religious.

McCready and Greeley (1976) attempted to break from the tradition of behavioral inquiry that asked whether people were more or less religious. They felt that the pertinent question was what do people think of the ultimate order of things. If one asks this question, one must also ask what impact do such values have on concerns about death.

Death Education Programs

Denton and Wisenbaker (1977) have written that although the effect of death anxiety on the care of the dying patient is for the most part unresearched, it is logical to argue that any form of anxiety reduces the ability of an individual to perform tasks in a setting where anxiety is aroused. In fact, Ross (1978) found that if a professional nurse did not mask fear of death through denial but rather recognized concerns about his/her own death, the nurse was better able to treat the dying patient. A death

education program might help remove denial, thus motivating a nursing student to experience, explore, and resolve death fear (Combs, 1978). Research has indicated that baccalaureate nursing students do view death education as helpful and desire assignments to care for dying patients (Castro-novo, 1978).

Numerous authors have urged that death education courses be offered to nursing students (Birch, 1979; Epstein, 1975; Mandel, 1981; Quint, 1964; Schoenberg, 1969; Watson, 1968). Despite the avowals of most nursing educators of the need for such programs, Thrush, Paulus, and Thrush (1979) found that of 205 randomly sampled nursing schools, only 5% reported offering a required death and dying course, while an additional 39.5% indicated that a death and dying course was available for their students on an elective basis.

A number of studies have indicated the effectiveness of death education programs with nurses and nursing students. Yeaworth, Kapp, and Winget (1974) evaluated the effectiveness of an integrated curriculum on death and dying. The curriculum stressed small group learning, encouraged faculty-student interaction, and included clinical experiences at extended care facilities. Those students participating in the program had significantly greater acceptance of feelings, more open communication, and broader flexibility in relating to dying patients and their

families. Leviton and Fretz (1978) also found that a death education course affected students' views in a positive way. At the end of the course the students viewed dying patients as more approachable and wished to experience death in a more interpersonal fashion as compared to a technological context.

Miles (1980), Murray (1974), and Redick (1974) demonstrated that death education programs could result in a decrease of death anxiety. Miles found that a 6 week small group experience produced significant change in death anxiety and attitudes toward death among nurses working in high risk areas of the hospital. Redick conducted a field experiment designed to investigate the effectiveness of a behavioral group procedure, group systematic desensitization. The program appeared to be effective in reducing the death anxiety of student nurses. Murray studied the effect of a death education program for registered nurses. The program consisted of six 1.5 hour sessions spaced 1 week apart, with relevant readings distributed at the end of each session. Death anxiety decreased significantly during the 4 weeks after completion of the session, but not during the 6 weeks of the program. The interim following the completion of the course may have provided the nurses with time for reflection upon their feelings and attitudes toward death. The results of these studies support the contention that

death anxiety is not a fixed entity but is sensitive to environmental events, including educational intervention.

Research has also indicated that death education programs can favorably influence death attitudes. Bailey (1976), Bugen (1980-81), Kasmarick (1974), McDonald (1981), and Watts (1977) showed this to be the case with undergraduate college students. Using a death education program which included videotaped symbolic modeling sequences, large and small group discussions, and a role playing direction activity, Poynor (1975) was also able to modify the death attitudes of nurses working on terminal care hospital units.

Bell (1975) and Durlak (1978) were concerned with assessing the effectiveness of death education in changing both the affective dimension, death anxiety, and the cognitive dimension, death attitudes. Bell utilized an experimental format to examine the influence of an 18 week course on the social aspects of death and dying. The data indicated significant changes in the attitudes of those in the experimental group. These individuals entertained more frequent thoughts of death and manifested a greater amount of interest in death-related discussion than was true of the control group. Items constituting the affective dimension, however, were not appreciably changed by experimental procedures. Both groups indicated approximately the same degree of fear in relation to death, and expressed similar feelings toward discussing their own or a close friend's death with

other persons. Durlak examined the impact of a death and dying workshop on attitudes toward life and death. The workshop was a voluntary 8 hour, small group experience for hospital staff. One of the workshop groups participated in an educational program emphasizing lecture presentations and small group discussion. In contrast, the second workshop group confronted, examined, and shared their own feelings and reactions to grief and death. Role playing, death awareness, and grief exercises were used for this purpose. Data indicated that the second group showed a significant reduction in death anxiety and fear of death attitudes as a result of the workshop, whereas both the didactic and control groups changed negatively over time. These results seem to support the view that an emotional, personal approach to death is an important element in an effective death education program.

Pine (1977) suggests that personal attitudes toward death and dying are difficult to change and the degree of change will differ from person to person. He does however hold that collective attitudes do seem to change through participation in death education programs. In order to change death-related attitudes it is essential that not only the cognitive but also the affective dimension, death anxiety, be considered (Triandis, 1971). Corr (1978) recommends that films, filmstrips, and recordings be utilized in death education in order to provide immediate images and a common

reference point for students to respond to. The hope is that immediate reactions and spontaneous feelings will be evoked before complex filtering and screening processes begin to operate.

Thus far the cited studies indicate that some significant degree of attitude change and anxiety reduction concerning death and dying issues can be induced through death education. A few researchers, however, have reported mixed or little success with such programs. Unlike Redick (1974) for example, Bohart and Bergland (1979) found that systematic desensitization, as well as symbolic modeling, was not effective in reducing the death anxiety of college students. Denton and Wisenbaker (1977) point out that such programs are based on the assumption that experience with death and dying is inversely related to death anxiety. However, in a study of death experience and death anxiety among 76 nurses and nursing students, they found that this assumption was only partially supported.

It is interesting to note that Yeaworth, Kapp, and Winget (1974) successfully modified death attitudes through a death education program that included clinical experience. Whereas, Hopping (1977), Swain and Cawles (1982), and Wieczorek (1975) found that cognitive instruction alone was insufficient in altering death attitudes. It should be noted, however, that Wieczorek did not use a control group, and Hopping was unable to randomly assign subjects to the

treatment groups. Swain and Cawles (1982) and Wieczorek (1975) did indicate some positive consequences resulting from their death education programs. Wieczorek concluded that small group discussions with peers provided a positive means by which students could share their feelings; and Swain and Cawles found that students had a better understanding of their personal concerns about death, and had acquired greater knowledge about this area. The importance of clinical experience in death education programs has also been highlighted by Goodell, Donohue, and Benoliel (1982). They found that young physicians ranked clinical and close personal experiences with death as more important in contributing to their present level of skill and confidence than didactic presentations. When asked which formats or techniques were likely to be effective in presenting the issues surrounding the dying patient, 30% of the physicians said patient/family interviews in class, 25% listed videotapes/films, and 24% recommended small group discussion.

It is possible that implicit elements in the professional education of nurses work against achieving success with death education programs. Sinacore (1981) believes that there is a basic incompatibility between contemporary death education and the fundamental education of health care professionals. Programs on death and dying explicitly require learners to focus on the affectual and experiential aspects of their patients and of themselves, yet there are

implicit elements in nursing education that keep the attention of the student centered on technological factors.

Benoliel (1982) has pointed out that in the case of death and dying, schools of nursing have been observed to emphasize lifesaving activities and technical skills with little systematic attention to the psychosocial complexities of nursing practice in terminal care. Sinacore (1981) believes that as a result, the humanistic aspects of death and dying are avoided by the student because of the need to fulfill the technological expectations of the nursing profession.

Some researchers have reported a very interesting finding, namely that death education resulted in a significant increase in death anxiety and fear of death attitudes. Epley, Hoelter, and McCaghy (1977) found that college students completing a course on death and dying reported significant increases in levels of death anxiety and increased negative attitudes toward the terminally ill. Similarly, Mueller (1976) noted that she had increased the fear of death of early adolescents after presenting them with a 12 lesson religious education unit concerned with death. Combs (1981) and Wittmaier (1979-80) also found that their death education programs unexpectedly increased the death anxiety of their subjects. Epley, Hoelter, and McCaghy (1977) offer a possible explanation for the findings. They suggest that death education may serve to increase the students' awareness of personal mortality, which may be responsible for

greater death anxiety and increased negative attitudes toward the dying person.

Thus far studies have been cited indicating contradictory results. Some support the effectiveness of death education in reducing death anxiety and altering attitudes toward death, other do not, and still others found that death education increased death anxiety and fear of death attitudes. It is understandable that Hoelter and Epley (1979) would conclude that since no discernible trends have emerged from research findings, a general conclusion cannot be drawn concerning the effects of death education.

In summary, death education programs for nursing students seem warranted in order to help students deal with their own feelings and more importantly, to insure the best care of the dying patient. Research evaluating the effectiveness of such programs in reducing death anxiety and fear of death attitudes has been contradictory. Some studies support the effectiveness of death education, others do not, and still others found that death education increased death anxiety and fear of death attitudes. Further research effort may help to determine just what kinds of programs will be effective in helping student nurses form the knowledge base, affective capability, and relatively stressless perspective they will need to be of maximum help to their patients.

Several authors have made recommendations for death education programs. Triandis (1971) stressed the need to consider both the cognitive dimension, namely death attitudes, and the affective dimension, death anxiety. Both Durlak (1978) and Corr (1978) recognize the importance of the affective dimension in death education. Durlak supports the view that an emotional, personal approach to death is an important element in an effective death education program. Corr recommends achieving this end through films, filmstrips, and recordings. Such methods of instruction provide immediate images and a common reference point for students to respond to. The hope is that immediate reactions and spontaneous feelings will be evoked before complex filtering and screening processes begin to operate. The importance of clinical experience with the dying has also been noted (Wieczorek, 1975; Yeaworth, Kapp, & Winget, 1974). Goodell, Donohue, and Benoliel (1982) found that young physicians ranked clinical experience with the dying as being more important in contributing to their present level of skill than didactic presentations.

Summary and Hypotheses

It is logical to argue that anxiety on the part of the student nurse may reduce his/her ability to care for the dying patient. Numerous authors document the considerable stress experienced by nurses on intensive care and oncology wards of the hospital, as well as the strong emotions some-

times experienced when sudden death is encountered. The many varied emotions and needs of the patient are not easily met by nurses who may be technically well trained, but feel overwhelmed by the many divergent demands made on them. Many nurses have indicated the need for nursing education to assist students in reducing their death anxiety so that they are better able to support and comfort the dying.

Nurses, like other health care professionals and human beings in general, hold complex attitudes toward death. They have indicated concerns about suffering, pain, a shortened life, unfulfilled goals, loss of control or power over their life, and fear for those that would be left behind should they die.

Given the complexity of each person's attitudes toward death, researchers have urged that death attitudes be treated in multidimensional terms which would take into consideration varying positive and negative perspectives on death and dying. Hoelter (1979) has developed a reliable scale for the measurement of fear of death attitudes, which is based on a multidimensional conception of fear of death. He defined fear of death as "an emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation or anticipation of any of eight facets related to death." These eight facets are fear of the dying process, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious

death, fear for the body after death, and fear of premature death.

In the last few years researchers have also begun to turn their attention to the relationship between religious values, death anxiety and fear of death attitudes. Such research has been contradictory. The discrepancies in research findings could be due to the fact that the nonreligious appear to fear death less than the minimally or extrinsically religious, but they experience a greater fear of death than persons of strong religious convictions who are intrinsically religious.

McCready and Greeley (1976) attempted to break from the tradition of behavioral inquiry that asked whether people were more or less religious. They felt that the pertinent question was concerned with how people view the ultimate order of things. If one asks this question, one must also inquire as to the impact of such values on concerns about death.

Death education programs for nursing students seem warranted in order to help students deal with their own feelings and more importantly, to insure the best care of dying patients. Research evaluating the effectiveness of such programs in reducing death anxiety and fear of death attitudes has been contradictory. Some studies support the effectiveness of death education, others do not, and still others found that death education increased death anxiety

and fear of death attitudes. Further research effort may help to determine just what kinds of programs will be most effective in helping student nurses form the knowledge base, affective capability, and relatively stressless perspective they will need to be of maximum help to their patients.

Some authors have made recommendations for death education programs. Triandis (1971) stressed the need to consider both the cognitive dimension, namely death attitudes, as well as the affective dimension, death anxiety. Both Durlak (1978) and Corr (1978) recognize the importance of the affective dimension in death education. Durlak supports the view that an emotional, personal approach to death is an important element in an effective death education program. Corr encourages the use of films, filmstrips, and recordings. Such methods of instruction provide immediate images and a common reference point for students to respond to. The hope is that immediate reactions and spontaneous feelings will be evoked before complex filtering and screening processes begin to operate. The importance of clinical experience with the dying has also been noted (Wieczorek, 1975; Yeaworth, Kapp, & Winget, 1974). Goodell, Donohue, and Benoliel (1982) found that young physicians ranked clinical experience with the dying as being more important in contributing to their present level of skill than didactic presentations.

In light of the previous discussion, the following null hypotheses were tested:

1. There is no significant difference in death anxiety, as assessed by the State Anxiety Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
2. There is no significant interaction effect between treatment and level of student with regard to death anxiety.
3. There is no significant difference in fear of death attitudes concerned with dying, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
4. There is no significant difference in fear of death attitudes concerned with the dead, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.

5. There is no significant difference in fear of death attitudes concerned with being destroyed, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
6. There is no significant difference in fear of death attitudes concerned with significant others, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
7. There is no significant difference in fear of death attitudes concerned with the unknown, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
8. There is no significant difference in fear of death attitudes concerned with conscious death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program

and baccalaureate nursing students not receiving this program.

9. There is no significant difference in fear of death attitudes concerned with the body after death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
10. There is no significant difference in fear of death attitudes concerned with premature death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
11. There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes.
12. There is no significant interaction effect between treatment and ultimate values type, as assessed by the Ultimate Values Typology, with regard to death anxiety.
13. There is no significant interaction effect between treatment and ultimate values type, as

assessed by the Ultimate Values Typology, with regard to fear of death attitudes.

CHAPTER III

METHODOLOGY

This chapter will include a presentation of (a) subjects, (b) procedure, (c) instrumentation, (d) design and statistical analysis, and (e) strengths and limitations.

Subjects

Junior and senior baccalaureate nursing students in a private, sectarian liberal arts college were asked to voluntarily participate in this study. The junior students took part in the study during the winter term, and the seniors during the spring term. Of 28 junior nursing students and 37 senior nursing students, 22 juniors and 32 seniors agreed to participate in this study.

Junior subjects ranged in age from 19 to 23 years with a mode of 20 years, and seniors ranged in age from 20 to 26 years with a mode of 21 years. With regard to marital status, 3 juniors (13.6%) and 5 seniors (15.6%) were married, and the remainder of the subjects were single. Four juniors (18.2%) and 4 seniors (12.5%) stated they were Catholic, 17 juniors (77.3%) and 28 seniors (87.5%) noted they were Protestant, and 1 junior indicated no religion. Of those subjects identifying a religion, 15 juniors (71.4%)

and 27 seniors (84.4%) stated they were practicing their religion. All of the juniors and 30 seniors (93.8%) were caucasian, and 2 of the seniors (6.2%) were black. Juniors had a grade point average ranging from 2.00 to 3.79 with a mode of 3.00, and seniors had a grade point average ranging from 2.00 to 3.99 with a mode of 3.00. With regard to living arrangements, 12 juniors (54.2%) and 19 seniors (59.4%) lived on-campus, and the remainder of the subjects lived off-campus in their own apartments or their parents' home. The average student in this study was 20.5 years old, single, Protestant, and caucasian, with a grade point average of 3.00. Approximately half of the students lived on-campus.

Procedure

Potential participants were contacted the first day of class and an explanation was given of the purpose of the study and its possible benefits, as well as the procedures to be used. They were informed that no known potential risks were involved, confidentiality would be respected and maintained, the subjects could withdraw from participation at any time, and all reasonable inquiries made concerning the procedures would be answered. A copy of the consent form (see Appendix A) was given to those students who expressed an interest in participating in the study. Additional inquiries concerning the study were answered and

those subjects agreeing to participate were asked to sign the consent form.

The junior and senior nursing students participating in the study were randomly assigned to either the experimental or the control group. The randomization procedure consisted of numbering the juniors from 1 to 22 and drawing the numbers 1 through 22 from a table of random numbers. The first 11 numbers that were drawn constituted one group and the second 11 numbers constituted the second group. The experimental treatment was then assigned at random to the groups. This same procedure was used with the seniors.

The experimental and control groups came together in a classroom in order to view a film, The Day Grandpa Died, which depicts a young Jewish boy's experiences when his grandfather dies. The film shows parent-child interactions in adjusting to the loss, the ways in which children react during grief, and the importance of the funeral ritual as friends gather to commemorate the grandfather's memory. Following the film, all the subjects were asked to complete the State Anxiety Scale (see Appendix B), the Multidimensional Fear of Death Scale (see Appendix C), and the Ultimate Values Typology (see Appendix D). The instruments were administered by the author, and the importance of not discussing the study prior to the completion of the research was stressed.

The experimental group was randomly divided into smaller groups of no more than seven student nurses. The smaller experimental groups continued to meet in the classroom 1 hour a week for 5 sessions. Times for the meetings were determined by the students' schedules. Each session consisted of an audio-visual presentation followed by a guided group discussion. Synopses of the films and audio cassettes, as well as discussion questions used in the program are in Appendix E.

In the first session, a filmstrip and audio-cassette, Gramp: A Man Ages and Dies, was shown after the students had the opportunity to read a brief introduction to the filmstrip. The theme of the tape concerns Gramp's last days of life in which his family decided to care for him at home. Gramps was senile, had no bowel control, and had decided to hasten death by removing his teeth and refusing to eat. The program stresses that care of a dying person can be a rewarding experience; that dying is a natural part of life. A 30 minute discussion which was guided by a list of distributed pertinent questions followed.

At the second session, on a 12 minute segment of the audio-cassette, Facing Death with the Patient: An On-Going Contract, Dr. Vincent Hunt of the University of Minnesota Medical School, described his own personal experiences in caring for dying patients, the general principles he had found effective, and the on-going contract he formed with

the patient to ensure the best possible care. He especially emphasized the importance of honesty in dealing with the patient, the willingness to answer questions, and the promise to seek necessary consultation. The remainder of the first 30 minutes of session 2 was spent in discussing the tape. The discussion was guided by distributed questions. In addition to Dr. Hunt's presentation, the first part of a 60 minute taped interview with Ms. Karen McArdle, R.N., M.S.N., the program director of a hospice program at St. Therese Hospital, Waukegan, Illinois, was played for the students. The interview was conducted by the author with Ms. McArdle in the fall of 1981. Ms. McArdle, one of the most experienced nurses in the Chicago area hospice movement, discussed attitudes about death, experiences with dying patients, and the nurse's role in caring for the dying. A 10 minute discussion guided by pertinent questions concluded the second session.

In the third session, the last 40 minutes of the taped interview with Ms. McArdle was presented to the students. A twenty minute discussion followed, which was based on distributed questions.

The fourth session featured the showing of a 40 minute segment of the film, Death. This film is an accurate and realistic depiction of the views of doctors and staff nurses about death, the responses of the staff to dying patients, and the last days before the death of a 51 year

old patient, Albro Pearsall. The film, shot in Calvary Hospital, New York City, has in the past proved to be provocative and helpful in eliciting discussion. In the last 20 minutes of session 4, students were encouraged to discuss their reactions to the film utilizing distributed questions.

At the fifth session the following week, an audio-cassette, Conversation with a Dying Friend, was played. In this 30 minute tape, Connie Goldman, of the University of Minnesota Center for Death Education, converses with a dying friend. The interview gives a personal account of the fear and frustration associated with imminent death. After this presentation, 30 minutes was devoted to discussion guided by a list of distributed pertinent questions.

At the completion of the death education program, subjects in both the experimental and control groups met again for approximately 30 minutes. The film, Soon There Will Be No More Me, was viewed. This is the filmed diary of the innermost thoughts of Lyn Helton, a young wife and mother who was dying of cancer. Following the film, the State Anxiety Scale and the Multidimensional Fear of Death Scale were again administered to all the student nurses.

Instrumentation

Three instruments were used to measure the variables of interest: (a) State Anxiety Scale, (b) Multidimensional Fear of Death Scale, and (c) Ultimate Values Typology.

State Anxiety Scale

The State Anxiety Scale (Spielberger, Gorsuch, & Lushene, 1970) consists of 20 brief items designed to measure state anxiety, a transitory condition of perceived tension (see Appendix B). College students ordinarily take 6-8 minutes to complete the scale. The test manual provides clear instructions for administration and scoring as well as norms.

The State Anxiety Scale is considered to be a good standardized measure of state anxiety. Test-retest reliability for the state scale ranges from .16 to .31 for college students. The low test-retest reliability for the state scale is to be expected since this is not a measure of a persistent characteristic. Internal consistency of the state scale as measured by the Kuder-Richardson formula 20, ranges from .83 to .92. Predictive validity of the state anxiety scale was determined by comparing scores of undergraduates in different states of mental stress. The state scale proved to be a reliable measure of increases in the state of anxiety resulting from experimental manipulation.

Multidimensional Fear of Death Scale

The Multidimensional Fear of Death Scale (Hoelter, 1979) consists of eight independent subscales designed to measure different fear of death attitudes, namely fear of dying, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious

death, fear for the body after death, and fear of premature death (see Appendix C). There are 42 items that include the responses of strongly disagree, disagree, neutral, agree, and strongly agree. Responses are rated from 1 (for strongly disagree) through 5 (for strongly agree). It takes 5-10 minutes to administer.

The mean reliability coefficient is .75, which is higher than other multidimensional fear of death scales. Current unidimensional scales have reported reliability coefficients around .90. However, their dimensional assumptions are suspect. Construct validity was demonstrated in that the fear of the unknown subscale had a strong negative relationship to religious orthodoxy ($r = -.64$); and four other subscales correlated positively with religious orthodoxy, namely fear for significant others ($r = .20$, $p < .01$), fear of conscious death ($r = .21$, $p < .01$), fear of being destroyed ($r = -.14$, $p < .01$), and fear for the body after death ($r = .10$, $p < .05$). These results were expected since theory suggests that fear of the unknown aspects of death is negatively related to religiosity, whereas other types of fear of death attitudes relate positively to religiosity (Becker, 1973; Vernon, 1970). Other evidence of reliability included 30-35 interviews with subjects who, after completing the scales, agreed that the instrument measured the various aspects of what they perceived fear of death attitudes to be. Evidence concerning discriminant validity has also been obtained.

All eight of the subscales were differentiated from the Trait Anxiety Scale (Spielberger, Gorsuch & Lushene, 1970).

Ultimate Values Typology

The Ultimate Values Typology (McCreedy & Greeley, 1976) consists of six vignettes asking respondents how they would respond to a critical life situation (see Appendix D). The respondent is asked to circle one of eight statements that comes closest to expressing their reaction to each vignette. Statements (a) and (e) are coded as secular optimism, statement (b) as religious optimism, statements (c) and (d) as pessimism, statement (f) as hopeful, and statements (g) and (h) as missing data.

The responses to the vignettes are summed for each category. A respondent could, for example, have given the hopeful response for none of the vignettes, or for all of them, or for some portion of them. Missing data for the vignettes is tabulated and converted into missing data for the typology. If a respondent did not give a usable answer to any of the vignettes, they are coded as missing for the typology. The sum of the responses for each category are collapsed. Respondents with 0, 1, or 2 are coded as 1, and those with 3, 4, or 5 are coded as 2. For example, if a person gave the hopeful response to none or one or two of the vignettes, they are coded as 1 in the hopeful category. If they gave more than two hopeful responses they are coded as 2. All of the four categories are multiplied by succes-

sive products of 10. The formula is: (Pessimism x 1) + (Secular Optimism x 10) + (Religious Optimism x 100) + (Hopeful x 1000). A computed score of 1111 or 1122 is assigned the typology of diffuse, a score of 1112 is assigned the typology of pessimist, a score of 1121 is assigned the typology of secular optimist, a score of 1211, 1212, or 1221 is assigned the typology of religious optimist, and a score of 2111, 2112, 2121, or 2211 is assigned the typology of hopeful. It takes 5-10 minutes to administer the Ultimate Values Typology.

Discriminant validity has been demonstrated in that a variety of demographic, familial, religious, and attitudinal variables theoretically associated with the ultimate values types have been found to be related to ultimate values types of persons in the American population. One would expect the ultimate values types to be distributed differently through different demographic groups of the population. The young and the minorities might be more pessimistic, as might the well educated. Those from rural areas might well be more hopeful and optimistic, since they have not experienced failures of urban society.

As expected, religious optimists tend to be female, older, black, and from the South. They are also poorer, not so well educated, and Protestant. The hopefuls are somewhat younger, slightly better educated, and are likely to be Protestant or Irish Catholic. The secular optimists are

more frequently British or German Protestants, college-educated, and from the Northeast. Pessimists are over-represented among the young, among those with college educations, and among Irish Catholics and Jews. The diffuse are more likely to be Italian Catholic or Jewish, and to live in either the Midwest or the Northwest. As expected, the religious behavior of parents and the structure of family life had an influence on the shaping of ultimate values. Those from more religious families and from families where relationships were perceived as closer were more likely to be religious optimists. Those from less religious and less intimate families were more likely to be pessimists. The religious optimists are more likely to be religious in the traditional sense and pessimists are more likely to be non-religious. Hopefuls are somewhat more likely than religious optimists to be certain of survival after death and to think of themselves as close to God.

The quality of life as measured by life satisfaction, psychological well-being, and marital adjustment is affected by ultimate values as expected, with the pessimists being much less satisfied with the quality of their lives. Ultimate values have a moderate effect on social and ethical attitudes, with the religious optimists being more conservative and the pessimists more liberal.

Design and Statistical Analysis

The randomized experimental group--control group,

pretest-posttest design was utilized in this study. The independent variables are treatment group, ultimate values type, and level of student. However, due to an insufficient number of subjects it was not possible to analyze data concerned with ultimate values type. The dependent variables are death anxiety and fear of death attitudes (fear of dying, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death). Each of these fear of death attitudes was separately analyzed.

In order to determine if there was a significant difference between the pretest scores of the treatment group and the pretest scores of the control group, the pretest scores were statistically analyzed using factorial analysis of variance, with a significance level of .05. No significant difference was found between the pretest scores of the treatment group and the pretest scores of the control group. Therefore, the statistical analysis employed was factorial analysis of variance for the posttest scores, with a significance level of .05. If a significant difference had been found between the pretest scores of the treatment group and the pretest scores of the control group, the statistical analysis that would have been employed is analysis of covariance with the pretest scores as the covariate. This method is more precise than gain score analysis and is

recommended by Cambell and Stanley (1963), Cook and Campbell (1979), Isaac and Michael (1971), and Kerlinger (1973).

Factorial analysis of variance allows one to analyze the independent and interactive effects of the independent variables on the dependent variables (Hays, 1973). Post-hoc comparisons were made using Tukey's - HSD test of differences between means, with a significance level of .05.

Tukey's - HSD test is more conservative than the t-test and thus lessens the probability of Type I error (Williams, 1979). The death anxiety scores were derived from the State Anxiety Scale, and the scores for the fear of death attitudes were derived from the Multidimensional Fear of Death Scale.

The Statistical Package for the Social Sciences, an integrated system of computer programs, was used to accomplish the statistical procedures mentioned above.

CHAPTER IV

RESULTS

This chapter presents the results of the statistical procedures employed in the study.

Hypotheses 1 and 2

- H₀ There is no significant difference in death anxiety, as assessed by the State Anxiety Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H₀ There is no significant interaction effect between treatment and level of student with regard to death anxiety.

The mean and standard deviation of the death anxiety scores at pretesting and posttesting for each treatment group are presented in Table 1.

In order to determine if the experimental and control groups were comparable with regard to level of death anxiety prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 2. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Table 1

Mean and Standard Deviation of the Death Anxiety Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	35.2500	12.8712	26.9375	4.7675
Senior Control	16	32.0625	7.6286	33.3125	8.2682
Junior Experimental	11	41.7273	6.6044	47.0909	11.5884
Junior Control	11	43.6364	9.1572	36.8182	7.1808

Table 2
Analysis of Variance for the Death Anxiety Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	16.667	1	16.667	0.180	0.673
Level of Student	1062.008	1	1062.008	11.462	0.001*
Treatment Group x Level of Student	84.660	1	84.660	0.914	0.344
Residual	4632.637	50	92.653		
Total	5795.973	53	109.358		

Note. (*) denotes F is statistically significant ($p \leq .05$).

Analysis of variance for the posttest death anxiety scores, with a significance level of .05, was used to test major hypotheses 1 and 2. The results are shown in Table 3. For treatment groups the F ratio was 0.035 ($p = 0.853$), which is not significant. However, there was a significant interaction effect between treatment and level of student with an F ratio of 14.005, which is significant at 0.000. Figure 1 illustrates this interaction effect.

The data was further analyzed using Tukey's - HSD test of differences between means, with a significance level of .05. The results are reported in Table 4. The posttest mean death anxiety score of the senior experimental group is significantly different from that of both the junior experimental and control groups, but not that of the senior control group. The posttest mean death anxiety score of the junior experimental group is significantly different from that of the senior experimental and control groups, as well as that of the junior control group.

Figure 2 illustrates the pretest to posttest mean death anxiety scores of the junior and senior experimental and control groups. In order to examine the change scores for each group, the correlated T-test with a significance level of .05 was used. The results are shown in Table 5. The mean death anxiety score of the senior experimental group significantly decreased from pretesting to posttesting ($t = 2.90$, $p = 0.011$). There was no significant change in

Table 3
Analysis of Variance for the Death Anxiety Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	2.241	1	2.241	0.035	0.853
Level of Student	1824.379	1	1824.379	28.286	0.000*
Treatment Group x Level of Student	903.293	1	903.293	14.005	0.000*
Residual	3224.892	50	64.498		
Total	5954.805	53	112.355		

Note. (*) denotes F is statistically significant ($p \leq .05$).

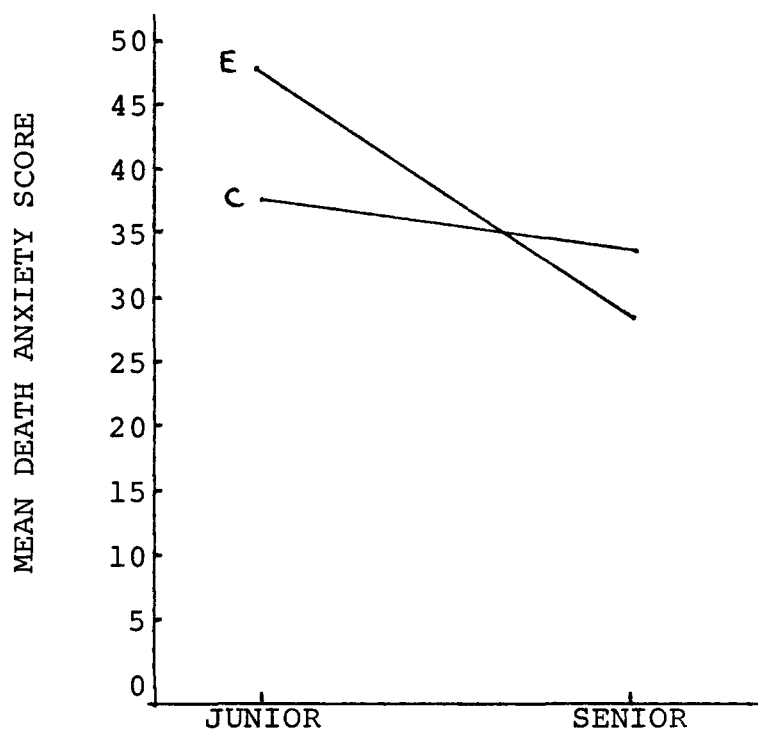


Figure 1. Illustration of interaction effect between treatment and level of student. (E) denotes experimental group and (C) denotes control group.

Table 4

Tukey's - HSD Test of Differences Between Mean Death Anxiety Scores
of Groups, Based on Level of Student and Treatment Group

Mean	Group	Group			
		1	2	4	3
26.9375	1				
33.3125	2				
36.8182	4	*			
47.0909	3	*	*	*	

Note. Group 1 is the senior experimental group, group 2 is the senior control group, group 3 is the junior experimental group, and group 4 is the junior control group. (*) denotes pairs of groups significantly different at the .05 level.

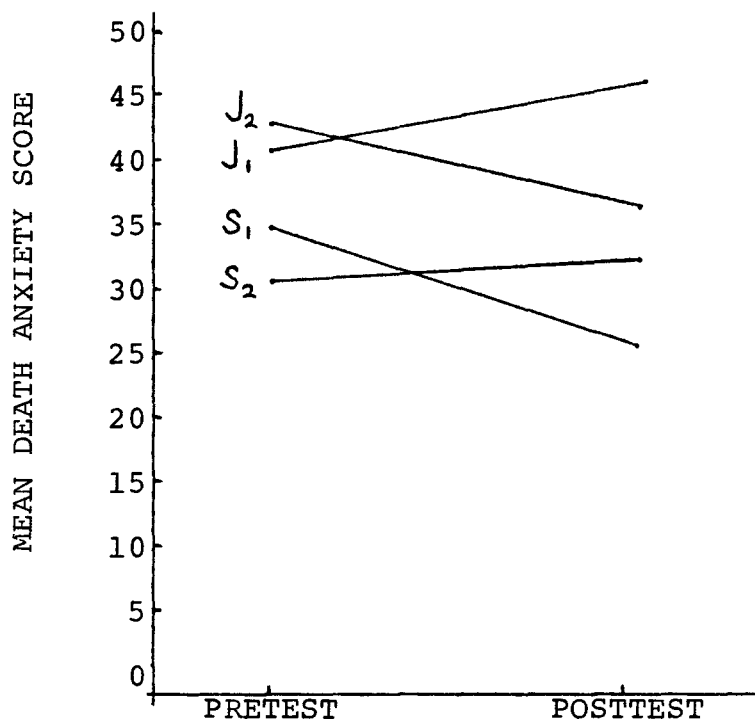


Figure 2. Illustration of pretest to posttest mean death anxiety scores of the treatment groups. (J_1) denotes junior experimental group, (J_2) junior control group, (S_1) senior experimental group, and (S_2) senior control group.

Table 5

Correlated T-Tests for the Death Anxiety Scores
of Each Treatment Group at Pretesting and Posttesting

Senior Experimental Group						
	N	Mean	Standard Deviation	Degrees of Freedom	t-Ratio	Significance
Pretest	16	35.2500	12.871	15	2.90	0.011*
Posttest	16	26.9375	4.768			
Senior Control Group						
Pretest	16	32.0625	7.629	15	-0.91	0.376
Posttest	16	33.3125	8.268			
Junior Experimental Group						
Pretest	11	41.7273	6.604	10	-1.54	0.155
Posttest	11	47.0909	11.588			
Junior Control Group						
Pretest	11	43.6364	9.157	10	2.59	0.027*
Posttest	11	36.8182	7.181			

Note. (*) denotes t is statistically significant ($p \leq .05$).

the mean death anxiety score of the senior control group from pretesting to posttesting ($t = -0.91$, $p = 0.376$). The mean death anxiety score of the junior experimental group increased, although not significantly, from pretesting to posttesting ($t = -1.54$, $p = 0.155$). There was a significant decrease in the mean death anxiety score of the junior control group from pretesting to posttesting ($t = 2.59$, $p = 0.027$). Therefore, null hypotheses 1 and 2 are rejected.

It should be noted that a significant difference was found between the pretest and posttest scores of juniors and seniors as indicated in Tables 2 and 3. Juniors experienced significantly more death anxiety than seniors.

Hypotheses 3 and 11

- H_0 There is no significant difference in fear of death attitudes concerned with dying, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H_0 There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with dying.

The mean and standard deviation of the fear of dying subscale scores at pretesting and posttesting for each treatment group are presented in Table 6.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear of dying subscale prior to the treatment, the pretest

Table 6
Mean and Standard Deviation of the Fear of Dying Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	20.7500	3.1091	20.3750	4.5148
Senior Control	16	20.5625	4.3813	19.8125	5.4799
Junior Experimental	11	21.3636	4.9653	21.4545	5.6985
Junior Control	11	21.4545	4.4354	20.1818	6.2421

scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 7. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear of dying subscale, with a significance level of .05, was used to test major hypotheses 3 and 11. The results are shown in Table 8. For treatment groups the F ratio was 0.333 ($p = 0.566$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 3 and 11 are not rejected.

Hypotheses 4 and 11

- H₀ There is no significant difference in fear of death attitudes concerned with the dead, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H₀ There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with the dead.

The mean and standard deviation of the fear of the dead subscale scores at pretesting and posttesting for each treatment group are presented in Table 9.

In order to determine if the experimental and control groups were comparable with regard to scores on the

Table 7

Analysis of Variance for the Fear of Dying Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	0.074	1	0.074	0.004	0.948
Level of Student	7.389	1	7.389	0.422	0.519
Treatment Group x Level of Student	0.253	1	0.253	0.014	0.905
Residual	867.206	50	17.524		
Total	883.922	53	16.678		

Table 8

Analysis of Variance for the Fear of Dying Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	9.796	1	9.796	0.333	0.566
Level of Student	6.842	1	6.842	0.233	0.632
Treatment Group x Level of Student	1.644	1	1.644	0.056	0.814
Residual	1470.546	50	29.411		
Total	1488.828	53	28.091		

Table 9

Mean and Standard Deviation of the Fear of the Dead Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	16.4375	2.4757	15.2500	2.2361
Senior Control	16	16.2500	3.9917	15.5625	2.4213
Junior Experimental	11	15.6364	3.8019	16.3636	4.1054
Junior Control	11	17.9091	2.5477	17.9091	3.5342

fear of the dead subscale prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 10. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear of the dead subscale, with a significance level of .05, was used to test hypotheses 4 and 11. The results are shown in Table 11. For treatment groups the F ratio was 0.982 ($p = 0.326$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 4 and 11 are not rejected.

It should be noted that a significant difference was found between the posttest scores of juniors and seniors as indicated in Table 11. Juniors had significantly more negative attitudes about the dead than seniors.

Hypotheses 5 and 11

- H_0 There is no significant difference in fear of death attitudes concerned with being destroyed, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.

Table 10
Analysis of Variance for the Fear of the Dead Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	8.693	1	8.963	0.829	0.367
Level of Student	2.399	1	2.399	0.222	0.640
Treatment Group x Level of Student	19.727	1	19.727	1.825	0.183
Residual	540.389	50	10.808		
Total	571.479	53	10.783		

Table 11

Analysis of Variance for the Fear of the Dead Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	8.963	2	8.963	0.982	0.326
Level of Student	39.024	1	39.024	4.275	0.044*
Treatment Group x Level of Student	4.955	1	4.955	0.543	0.465
Residual	456.390	50	9.128		
Total	509.331	53	9.610		

Note. (*) denotes F is statistically significant ($p \leq .05$).

- H₀ There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with being destroyed.

The mean and standard deviation of the fear of being destroyed subscale scores at pretesting and posttesting for each treatment group are presented in Table 12.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear of being destroyed subscale prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 13. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear of being destroyed subscale, with a significance level of .05, was used to test hypotheses 5 and 11. The results are shown in Table 14. For treatment groups the F ratio was 0.132 ($p = 0.718$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 5 and 11 are not rejected.

Hypotheses 6 and 11

- H₀ There is no significant difference in fear of death attitudes concerned with significant others, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate

Table 12

Mean and Standard Deviation of the Fear of Being Destroyed Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	10.8125	3.8853	10.7500	4.5534
Senior Control	16	10.6250	3.2223	10.1250	3.0523
Junior Experimental	11	10.6364	3.5573	10.6364	3.6680
Junior Control	11	12.0000	2.8983	12.4545	3.3871

Table 13

Analysis of Variance for the Fear of Being Destroyed Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	2.667	1	2.667	0.225	0.637
Level of Student	4.684	1	4.684	0.395	0.532
Treatment Group x Level of Student	7.842	1	7.842	0.662	0.420
Residual	592.729	50	11.855		
Total	607.922	53	11.470		

Table 14

Analysis of Variance for the Fear of Being Destroyed Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	1.852	1	1.852	0.132	0.718
Level of Student	16.004	1	16.004	1.143	0.290
Treatment Group x Level of Student	19.455	1	19.455	1.390	0.244
Residual	700.017	50	14.000		
Total	737.328	53	13.912		

nursing students receiving the death education program and baccalaureate nursing students not receiving the program.

- H₀ There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with significant others.

The mean and the standard deviation of the fear for significant others subscale scores at pretesting and post-testing for each treatment group are presented in Table 15.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear for significant others subscale prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 16. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear for significant others subscale, with a significance level of .05, was used to test hypotheses 6 and 11. The results are shown in Table 17. For treatment groups the F ratio was 0.525 ($p = 0.472$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 6 and 11 are not rejected.

Table 15

Mean and Standard Deviation of the Fear for Significant Others Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	24.0000	3.3267	23.8750	3.3640
Senior Control	16	23.3125	3.1983	22.5000	3.5214
Junior Experimental	11	23.9091	3.3303	23.6364	3.9818
Junior Control	11	23.3636	3.0421	23.9091	3.5058

Table 16

Analysis of Variance for the Fear for Significant Others Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	5.352	1	5.352	0.512	0.478
Level of Student	0.005	1	0.005	0.000	0.982
Treatment Group x Level of Student	0.066	1	0.066	0.006	0.937
Residual	522.888	50	10.458		
Total	528.311	53	9.968		

Table 17

Analysis of Variance for the Fear for Significant Others Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	6.685	2	6.685	0.525	0.472
Level of Student	4.465	1	4.465	0.350	0.557
Treatment Group x Level of Student	8.849	1	8.849	0.694	0.409
Residual	637.201	50	12.744		
Total	657.200	53	12.400		

Hypotheses 7 and 11

- H_0 There is no significant difference in fear of death attitudes concerned with the unknown, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H_0 There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with the unknown.

The mean and standard deviation of the fear of the unknown subscale scores at pretesting and posttesting for each treatment group are presented in Table 18.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear of the unknown subscale prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 19. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear of the unknown subscale, with a significance level of .05, was used to test hypotheses 7 and 11. The results are shown in Table 20. For treatment groups the F ratio was 0.541 ($p = 0.466$) which is not significant, and there was no significant interaction effect between treatment and level

Table 18

Mean and Standard Deviation of the Fear of the Unknown Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	9.0625	3.5678	9.0000	3.1623
Senior Control	16	9.5625	3.7053	9.1250	3.8449
Junior Experimental	11	10.3636	3.2641	10.2727	2.5802
Junior Control	11	7.9091	1.9725	8.4545	2.3394

Table 19
Analysis of Variance for the Fear of the Unknown Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	6.685	1	6.685	0.616	0.436
Level of Student	0.404	1	0.404	0.037	0.848
Treatment Group x Level of Student	28.451	1	28.451	2.623	0.112
Residual	542.325	50	10.846		
Total	577.866	53	10.903		

Table 20

Analysis of Variance for the Fear of the Unknown Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	6.000	1	6.000	0.541	0.466
Level of Student	1.182	1	1.182	0.107	0.745
Treatment Group x Level of Student	12.307	1	12.307	1.109	0.297
Residual	554.655	50	11.093		
Total	574.144	53	10.833		

of student. Therefore, null hypotheses 7 and 11 are not rejected.

Hypothesis 8 and 11

- H_0 There is no significant difference in fear of death attitudes concerned with conscious death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H_0 There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with conscious death.

The mean and standard deviation of the fear of conscious death subscale scores at pretesting and post-testing for each treatment group are presented in Table 21.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear of conscious death subscale prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 22. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear of conscious death subscale, with a significance level of .05, was used to test hypotheses 8 and 11. The results

Table 21

Mean and Standard Deviation of the Fear of Conscious Death Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	10.8750	3.0741	11.1875	3.4296
Senior Control	16	9.6250	2.5528	9.3125	3.0270
Junior Experimental	11	12.9091	3.4483	11.5455	3.7246
Junior Control	11	11.3636	2.8381	10.1818	3.7099

Table 22

Analysis of Variance for the Fear of Conscious Death Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	25.352	1	25.352	2.888	0.095
Level of Student	46.391	1	46.391	5.284	0.026*
Treatment Group x Level of Student	0.285	1	0.285	0.032	0.858
Residual	438.951	50	8.779		
Total	510.979	53	9.641		

Note. (*) denotes F is statistically significant ($p \leq .05$).

are shown in Table 23. For treatment groups the F ratio was 3.177 ($p = 0.081$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 8 and 11 are not rejected.

It should be noted that a significant difference was found between the pretest scores of juniors and seniors as indicated in Table 22. Juniors had significantly more negative attitudes about conscious death than seniors.

Hypotheses 9 and 11

- H_0 There is no significant difference in fear of death attitudes concerned with the body after death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H_0 There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with the body after death.

The mean and standard deviation of the fear for the body after death subscale scores at pretesting and post-testing for each treatment group are presented in Table 24.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear for the body after death subscale prior to the treatment, the pretest scores of the two groups were statistically analyzed using analysis of variance, with a significance level of .05. The results are shown in Table 25. No

Table 23

Analysis of Variance for the Fear of Conscious Death Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	37.500	2	37.500	3.177	0.081
Level of Student	4.909	1	4.909	0.416	0.522
Treatment Group x Level of Student	0.852	1	0.852	0.072	0.789
Residual	590.234	50	11.805		
Total	633.496	53	11.953		

Table 24

Mean and Standard Deviation of the Fear for the Body After Death Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	12.0000	4.6043	11.7500	3.7859
Senior Control	16	11.8750	3.4424	12.0625	3.7677
Junior Experimental	11	14.2727	4.0272	14.0909	3.8589
Junior Control	11	12.2727	3.1652	11.7273	3.4085

Table 25

Analysis of Variance for the Fear for the Body After Death Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	10.667	1	10.667	0.704	0.406
Level of Student	22.243	1	22.243	1.533	0.221
Treatment Group x Level of Student	11.458	1	11.458	0.756	0.389
Residual	758.108	50	15.162		
Total	803.476	53	15.160		

significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear for the body after death subscale, with a significance level of .05, was used to test hypotheses 9 and 11. The results are shown in Table 26. For treatment groups the F ratio was 0.589 ($p = 0.446$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 9 and 11 are not rejected.

Hypothesis 10 and 11

- H_0 There is no significant difference in fear of death attitudes concerned with premature death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
- H_0 There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes concerned with premature death.

The mean and standard deviation of the fear of premature death subscale scores at pretesting and post-testing for each treatment group are presented in Table 27.

In order to determine if the experimental and control groups were comparable with regard to scores on the fear of premature death subscale prior to treatment, the pretest scores of the two groups were statistically analyzed

Table 26

Analysis of Variance for the Fear for the Body After Death Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	8.167	1	8.167	0.589	0.446
Level of Student	13.111	1	13.111	0.946	0.335
Treatment Group x Level of Student	23.342	1	14.863	1.073	0.369
Residual	693.024	50	13.860		
Total	737.644	53	13.918		

Table 27

Mean and Standard Deviation of the Fear of Premature Death Subscale Scores
of Each Treatment Group at Pretesting and Posttesting

Treatment Group	N	Pretest		Posttest	
		M	SD	M	SD
Senior Experimental	16	12.5000	3.7594	11.5625	3.5397
Senior Control	16	11.8750	2.6552	12.1250	3.1596
Junior Experimental	11	12.0909	2.6629	12.6364	3.0421
Junior Control	11	13.6364	3.5291	13.3636	3.3248

using analysis of variance, with a significance level of .05. The results are shown in Table 28. No significant difference was found between the pretest scores of the experimental group and the pretest scores of the control group.

Analysis of variance for the posttest scores on the fear of premature death subscale, with a significance level of .05, was used to test hypotheses 10 and 11. The results are shown in Table 29. For treatment groups the F ratio was 0.495 ($p = 0.485$) which is not significant, and there was no significant interaction effect between treatment and level of student. Therefore, null hypotheses 10 and 11 are not rejected.

Hypotheses 12 and 3

H_0 There is no significant interaction affect between treatment and ultimate values type, as assessed by the Ultimate Values Typology, with regard to death anxiety.

H_0 There is no significant interaction effect between treatment and ultimate values type, as assessed by the Ultimate Values Typology, with regard to fear of death attitudes.

It was not possible to statistically analyze the data with regard to ultimate values type due to an insufficient number of subjects. In the senior experimental group there were 4 secular optimists, 0 religious optimists, 3 pessimists, 6 hopefuls, and 3 diffuse. The senior control group had 0 secular optimists, 1 religious optimist, 7 pessimists, 3 hopefuls, and 5 diffuse. In the junior exper-

Table 28

Analysis of Variance for the Fear of Premature Death Subscale Scores
at Pretesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	0.907	1	0.907	0.088	0.767
Level of Student	5.960	1	5.960	0.581	0.450
Treatment Group x Level of Student	15.354	1	15.354	1.496	0.227
Residual	513.200	50	10.264		
Total	535.422	53	10.102		

Table 29

Analysis of Variance for the Fear of Premature Death Subscale Scores
at Posttesting

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-Ratio	Significance
Treatment Group	5.352	1	5.352	0.495	0.485
Level of Student	17.429	1	17.429	1.612	0.210
Treatment Group x Level of Student	0.089	1	0.089	0.008	0.928
Residual	540.775	50	10.815		
Total	563.645	53	10.635		

imental group there was 1 secular optimist, 3 religious optimists, 1 pessimist, 3 hopefuls, and 3 diffuse. The junior control group had 0 secular optimists, 5 religious optimists, 1 pessimist, 3 hopefuls, and 2 diffuse. It should be noted that there were more seniors who were pessimists ($n = 10$) than juniors ($n = 2$), and more juniors who were religious optimists ($n = 8$) than seniors ($n = 1$).

Discussion of the Results

The mean death anxiety score of the senior nursing students, who received the death education program, significantly decreased from pretesting to posttesting. The standard deviation of the death anxiety scores of seniors in the experimental group was 12.8712 at pretesting at 4.7675 at posttesting. This finding, which indicates that the death education program was effective in decreasing the death anxiety of some of the seniors, tends to support the conclusions of Yeaworth, Kapp, and Winget (1974), Leviton and Fretz (1978), Miles (1980), Murray (1974), and Redick (1974) who demonstrated that death education programs could result in a decrease of death anxiety.

Junior nursing students receiving the death education program had a significantly higher mean death anxiety score at posttesting than juniors not receiving the death education program. The standard deviation of the death anxiety scores of juniors in the experimental group was 6.6044 at pretesting and 11.5884 at posttesting. This

finding, which indicates that the death education program increased the death anxiety of some of the juniors, tends to support the research findings of Combs (1981), Epley, Hoelter, and McCaghy (1977), Mueller (1977), and Wittmaier (1979-80), who noted a significant increase in death anxiety as a result of death education programs.

This discrepancy in the effect of the death education program on the death anxiety of juniors and seniors could be attributable to prior supervised clinical experiences. Junior students had little or not clinical experience with dying patients. Seniors however had supervised clinical experience with dying patients during the previous Fall term. A death education program that portrays death experiences through audio-visual materials but does not provide clinical experiences with the dying, may actually increase the death anxiety of some students. Providing such a program after clinical experiences with the dying may allow students to process their feelings and reactions to these experiences, and thus decrease their death anxiety.

One would suspect that prior personal experiences with death would influence the student's reaction to the two films used to elicit death anxiety. The pretest film portrayed a boy's experiences when his grandfather died, and the posttest film was concerned with a young wife and mother dying of cancer. This important variable was not measured

in this study, but it certainly deserves consideration in future research.

Clinical experience with the dying may account for the fact that senior students had lower scores on the fear of conscious death subscale than did juniors. The clinical experiences of seniors may have led them to disbelieve any likelihood of people being buried alive or pronounced dead when they are really alive. They may also have found it hard to believe that there is a need to perform autopsies to insure that people are actually dead, or that a person may actually be conscious while lying in a morgue, or that the pronouncement of a second doctor is needed to be assured that death has occurred.

There was no significant difference between junior and senior nursing students with regard to the mean scores on the remaining subscales of the Multidimensional Fear of Death Scale. In addition, there was no significant difference in fear of death attitudes between nursing students receiving the death education program and students not receiving the program. It is suggested that this is an indication of the difficulty of changing deeply embedded attitudes towards death. Neither supervised clinical experience with the dying patient nor the death education program were able to significantly decrease the majority of fear of death attitudes measured in the study.

CHAPTER V

SUMMARY, IMPLICATIONS

AND RECOMMENDATIONS

The first part of Chapter V will provide a brief summary of the first four chapters. It will include the following: purpose of study, review of the literature, hypotheses, methodology, and results. Following this brief recapitulation, the implications of the study, and recommendations for further research will be presented.

Summary

Purpose of the Study

The purpose of this study was to evaluate a death education program developed by the author. Two other considerations of this study were to investigate whether or not clinical experience with dying patients and the ultimate values type of the student nurse had any influence on effectiveness of the death education program in altering fear of death attitudes and death anxiety.

Review of the Literature

Numerous authors document the considerable stress experienced by nurses when encountering the dying patient (Benoliel, 1982; Birch, 1979; Castronovo, 1978; Mandel,

1981). A need exists for nursing education programs to assist students in reducing their death anxiety and fear of death attitudes. Some authors have made specific recommendations for death education programs. Triandis (1971) stressed the need to consider both the cognitive dimension, namely death attitudes, as well as the affective dimension, death anxiety. Both Durlak (1978) and Corr (1978) recognize the importance of the affective dimension in death education. Durlak supports the view that an emotional, personal approach to death is an important element in an effective death education program. Corr encourages the use of audiovisual aids to provide a common reference point for evoking spontaneous feelings. The importance of clinical experience with the dying has also been noted (Wieczorek, 1975; Yearworth, Kapp, & Winget, 1974).

Research evaluating the effectiveness of death education programs has been contradictory. Some studies support the effectiveness of death education, others do not, and still others have found that death education increased death anxiety and fear of death attitudes (Bohart & Bergland, 1979; Combs, 1981; Hopping, 1977; Kasmarick, 1974; Miles, 1980).

The nonreligious appear to fear death less than the minimally religious, but experience a greater fear of death than persons of strong religious convictions. Therefore, it is possible that the ultimate value type of the nursing

student might influence the effectiveness of a death education program.

Hypotheses

The following null hypotheses were tested:

1. There is no significant difference in death anxiety, as assessed by the State Anxiety Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program.
2. There is no significant interaction effect between treatment and level of student with regard to death anxiety.
3. There is no significant difference in fear of death attitudes concerned with dying, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
4. There is no significant difference in fear of death attitudes concerned with the dead, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and

baccalaureate nursing students not receiving this program.

5. There is no significant difference in fear of death attitudes concerned with being destroyed, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
6. There is no significant difference in fear of death attitudes concerned with significant others, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
7. There is no significant difference in fear of death attitudes concerned with the unknown, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
8. There is no significant difference in fear of death attitudes concerned with conscious death, as assessed by the Multidimensional Fear of

Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.

9. There is no significant difference in fear of death attitudes concerned with the body after death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
10. There is no significant difference in fear of death attitudes concerned with premature death, as assessed by the Multidimensional Fear of Death Scale, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving this program.
11. There is no significant interaction effect between treatment and level of student with regard to fear of death attitudes.
12. There is no significant interaction effect between treatment and ultimate values type, as assessed by the Ultimate Values Typology, with regard to death anxiety.

13. There is no significant interaction effect between treatment and ultimate values type, as assessed by the Ultimate Values Typology, with regard to fear of death attitudes.

Methodology

The subjects who participated in this study were 22 junior and 32 senior baccalaureate nursing students at a private sectarian liberal arts college. The average student was 20.5 years old, single, Protestant, and caucasian, with a grade point average of 3.00. Approximately half of the students lived on-campus. Students were randomly assigned to either the experimental or control groups. The State Anxiety Scale, the Multidimensional Fear of Death Scale, and the Ultimate Values Typology were administered to all the subjects after they viewed the film, The Day Grandpa Died. Following this procedure, the experimental group received the death education program. After the completion of the program, all the subjects viewed the film, Soon There Will Be No More Me, and the State Anxiety Scale and the Multidimensional Fear of Death Scale were again administered.

The randomized experimental group--control group, pretest-posttest design was utilized. The statistical analysis employed was factorial analysis of variance for the posttest scores with a significance level of .05. Post-hoc comparisons were made using Tukey's - HSD test of differences between means, with a significance level of .05.

Results

The results of the study are as follows:

1. Juniors had a significantly higher mean death anxiety score at pretesting and posttesting than did seniors.
2. The mean death anxiety score of the seniors, who received the death education program, significantly decreased from pretesting to posttesting.
3. Juniors receiving the death education program had a significantly higher mean death anxiety score at posttesting than did juniors not receiving the death education program.
4. Juniors had a significantly higher mean score on the fear of conscious death subscale at pretesting than did seniors.
5. Juniors had a significantly higher mean score on the fear of the dead subscale at posttesting than did seniors.
6. There was no significant difference in fear of death attitudes between students receiving the death education program and students not receiving the program.
7. There was no significant interaction effect between treatment and level of student with regard to fear of death attitudes.

8. Due to an insufficient number of subjects it was not possible to determine if a significant interaction effect existed between treatment and ultimate values type with regard to death anxiety and fear of death attitudes.

Implications

Since death anxiety and fear of death attitudes are two different dimensions of negative reactions to death, both ought to be evaluated when determining the effectiveness of a death education program. Contradictory research findings with regard to the effectiveness of death education programs may be attributable to the fact that death anxiety and fear of death attitudes are measured differently in various studies. If findings are to be compared, there needs to be greater consistency with regard to the instruments used.

One important implication of this study is that a death education program of the type offered without prior or accompanying supervised clinical experiences with dying patients may actually increase the death anxiety of student nurses. It is suggested that supervised clinical experiences with dying patients may be the most important part of a relevant death education program. Cognitive and didactic death education material introduced without previous or ongoing supervised clinical experience may actually increase death anxiety.

The death education module should be made available at the same time nursing students are having their first supervised clinical experiences with dying patients. The nursing instructor could incorporate separate sessions of the program into the theory lectures accompanying the clinical experiences or the module could be presented in clinical seminars. Another possibility would be to present the death education program to graduate nurses through a professional workshop.

Neither supervised clinical experiences with the dying nor the death education program succeeded in significantly changing the majority of negative attitudes towards death. Further research is needed in order to find an effective means of decreasing fear of death attitudes.

Due to an insufficient number of subjects it was not possible to determine if ultimate values typology influences the effectiveness of a death education program. This variable should be taken into consideration in future research.

Since the subjects in this study chose to attend a small Christian college and 75.9% were practicing a religion, this would seem to indicate that the majority have strong religious values. These values more than likely influence their attitudes toward death and anxiety concerning death. Nursing students attending a nonsectarian school could conceivably perceive death differently.

Recommendations for Further Research

Recommendations for further research are as follows:

1. This study should be replicated in a number of representative schools of nursing in order to control for the interaction effects of selection biases and the experimental variables. This would make it feasible to include as independent variables age, sex, and ethnic group.
2. In order to control for the experimenter bias effect, the person conducting the death education program should not be aware of the hypotheses of the experiment.
3. This study should be replicated with a larger number of subjects making it possible to (a) use the randomized Solomon four-group design which would control for the possibility that pretesting sensitized the subjects and (b) further analyze data concerning the Ultimate Values Typology.
4. It would be of interest to conduct a follow-up study in order to determine if subjects, who received the death education program, benefited from the program in terms of clinical performance.

5. An important variable that should be considered in future research is that of the subject's personal experiences with death.
6. The death education program could be modified by providing subjects with the opportunity to explore personal feelings and reactions through unstructured group counseling sessions.
7. An additional study seems in order. Nursing students should be assigned randomly to five groups. The first group would receive only supervised clinical experience with dying patients, and the second group would receive only the death education program. The third group would receive supervised clinical experience with the dying followed by the death education program, and the fourth group would receive such a clinical experience concurrently with the program. The last group would receive neither the supervised clinical experience with the dying nor the death education program. The purpose of the study would be to determine if supervised clinical experience with the dying patient is sufficient to decrease death anxiety or if a combination of supervised clinical experience and a death education program would be more effective in decreasing death anxiety.

8. Further research evaluating the effectiveness of death education programs should consider the ability of such programs to decrease both death anxiety and fear of death attitudes.

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APPENDIX A

CONSENT FORM

Project Title: Death Anxiety and Fear of Death Attitudes:
A Death Education Program for Student Nurses

I, _____, state that I am over 18 years of age and that I wish to participate in a program of research being conducted by Terry Lally.

Description of purpose and explanation of procedure:

The purpose of this study is (a) to determine if there is a significant difference in death anxiety experienced by baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program, (b) to determine if there is a significant difference in fear of death attitudes, namely fear of dying, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death, between baccalaureate nursing students receiving the death education program and baccalaureate nursing students not receiving the program, (c) to determine if the ultimate values type of the baccalaureate nursing student, namely diffuse, secular optimist, religious optimist, hopeful or pessimist, influences the effectiveness of the death education program in reducing death anxiety and fear of death attitudes, and (d) to determine if the level of the baccalaureate nursing student, junior or senior, influences the effectiveness of the death education program in reducing death anxiety and fear of death attitudes.

Subjects will be randomly assigned to either group A or group B. Both groups will view a 30 minute film, The Day Grandpa Died, and complete the State Anxiety Scale, the Multidimensional Fear of Death Scale, and the Ultimate Values Typology. The completion of these instruments will take approximately 20 minutes. Group A will be randomly divided into smaller groups of no more than seven subjects. These small groups will continue to meet one hour a week for 5 sessions in order to participate in a death education program emphasizing the use of audio-visual materials and group discussion. At the completion of the death education program, subjects in group A and group B will view an 11 minute film, Soon There Will Be No More Me, and again

complete the State Anxiety Scale and the Multidimensional Fear of Death Scale. The data collected during this study will be kept confidential. Students will be asked to write the last six numbers of their social security number on completed instruments instead of their name. After the completion of the investigation, an abstract of the study will be made available to those students requesting it.

Risks and discomfort:

No known potential risks are involved.

Potential benefits:

While student nurses will encounter death and dying throughout their careers, they like other medical personnel often have a difficult time coping with the stress of caring for the dying. The literature supports the need for programs designed to help student nurses examine and share their own feelings and reactions to grief and death. The death education program to be evaluated in this study will uniquely attempt to incorporate the most recent suggestions of previous researchers. Immediate concrete experiences that allow baccalaureate student nurses to tap their own perceptions of death will be provided by films and audio cassette tapes. Furthermore, past and present fears, hesitations, hurts, and attitudes related to death will be explored in supportive group sessions. Should this program prove to be effective in reducing nursing students' death anxiety and fear of death attitudes, it could be used to augment instruction on death and dying, bereavement, grief, and mourning as presented in nursing curriculums.

Benefits of the investigation for the baccalaureate nursing student volunteering as a participant in this study include: (a) the opportunity to learn more about oneself in terms of anxieties about death and attitudes toward death, (b) the potential opportunity to reduce anxieties about death and acquire more positive attitudes toward death, and (c) the opportunity to participate in a research study which will be a unique experience.

Alternatives:

No alternative procedures will be provided.

I acknowledge that Terry Lally has fully explained to me the need for the research and that no known risks are involved; has informed me that I may withdraw from participation at any time without prejudice; has offered to answer any inquiries which I may make concerning the procedures to

be followed; and has informed me that I will be given a copy of this consent form. I freely and voluntarily consent to my participation in the research project.

(Signature of Volunteer)

(Signature of Investigator)

(Date)

APPENDIX B

STATE ANXIETY SCALE

Subject Number _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Not at all	Somewhat	Moder- ately so	Very much so
1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I am tense	1	2	3	4
4. I am regretful	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible mis- fortunes	1	2	3	4
8. I feel rested	1	2	3	4
9. I feel anxious	1	2	3	4
10. I feel comfortable	1	2	3	4
11. I feel self- confident	1	2	3	4
12. I feel nervous	1	2	3	4

		Not at all	Somewhat	Moder- ately so	Very much so
13.	I am jittery	1	2	3	4
14.	I feel "high strung"	1	2	3	4
15.	I am relaxed	1	2	3	4
16.	I feel content	1	2	3	4
17.	I am worried	1	2	3	4
18.	I feel over-excited and "rattled"	1	2	3	4
19.	I feel joyful	1	2	3	4
20.	I feel pleasant	1	2	3	4

APPENDIX C

MULTIDIMENSIONAL FEAR OF DEATH SCALE

Subject Number _____ Date _____

DIRECTIONS: There are forty-two statements below about how a person might feel or think about death. Read each statement and then check the appropriate response to the right of the statement to indicate how you feel or think right now. There are no right or wrong answers. Do not spend too much time on any one statement. Make certain to respond to each statement. It will take 10 minutes or so to finish.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I am afraid of dying very slowly.	_____	_____	_____	_____	_____
2. I dread visiting a funeral home.	_____	_____	_____	_____	_____
3. I would like to donate my body to science.	_____	_____	_____	_____	_____
4. I have a fear of people in my family dying.	_____	_____	_____	_____	_____
5. I am afraid that there is no afterlife.	_____	_____	_____	_____	_____
6. There are probably many people pronounced dead that are really still alive.	_____	_____	_____	_____	_____
7. I am afraid of my body being disfigured when I die.	_____	_____	_____	_____	_____

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
8. I have a fear of not accomplishing my goals in life before dying.	_____	_____	_____	_____	_____
9. Touching a corpse would not bother me.	_____	_____	_____	_____	_____
10. If the people I am very close to were to suddenly die, I would suffer for a long time.	_____	_____	_____	_____	_____
11. I dread the thought of my body being embalmed one day.	_____	_____	_____	_____	_____
12. I am afraid of being buried alive.	_____	_____	_____	_____	_____
13. I am afraid of dying in a fire.	_____	_____	_____	_____	_____
14. Discovering a dead body would be a horrifying experience.	_____	_____	_____	_____	_____
15. I do not want medical students using my body for practice after I die.	_____	_____	_____	_____	_____
16. I am not afraid of meeting my creator.	_____	_____	_____	_____	_____
17. If I would die tomorrow, my family would be upset for a long time.	_____	_____	_____	_____	_____

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
18. I would be afraid to walk through a graveyard, alone, at night.	_____	_____	_____	_____	_____
19. I am afraid of experiencing a great deal of pain when I die.	_____	_____	_____	_____	_____
20. The thought of my body never being found after I die scares me.	_____	_____	_____	_____	_____
21. People should have autopsies to insure that they are dead.	_____	_____	_____	_____	_____
22. I am afraid of dying of cancer.	_____	_____	_____	_____	_____
23. I do not like the thought of being cre- mated.	_____	_____	_____	_____	_____
24. It would bother me to remove a dead animal from the road.	_____	_____	_____	_____	_____
25. Since everyone dies, I won't be too upset when my friends die.	_____	_____	_____	_____	_____
26. I am afraid that death is the end of one's exist- ence.	_____	_____	_____	_____	_____

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
27. It scares me to think I may be conscious while lying in a morgue.	_____	_____	_____	_____	_____
28. It doesn't matter whether I am buried in a wooden box or a steel vault.	_____	_____	_____	_____	_____
29. I am afraid I will not live long enough to enjoy my retirement.	_____	_____	_____	_____	_____
30. I have a fear of suffocating (including drowning).	_____	_____	_____	_____	_____
31. I am afraid of things which have died.	_____	_____	_____	_____	_____
32. I sometimes get upset when acquaintances die.	_____	_____	_____	_____	_____
33. I am afraid that there may not be a supreme being.	_____	_____	_____	_____	_____
34. I hope more than one doctor examines me before I am pronounced dead.	_____	_____	_____	_____	_____
35. I am afraid I will not have time to experience everything I want to.	_____	_____	_____	_____	_____

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
36. The thought of being locked in a coffin after I die scares me.	_____	_____	_____	_____	_____
37. I have a fear of dying violently.	_____	_____	_____	_____	_____
38. I do not want to donate my eyes after I die.	_____	_____	_____	_____	_____
39. If I died, my friends would be upset for a long time.	_____	_____	_____	_____	_____
40. No one can say, for sure, what will happen after death.	_____	_____	_____	_____	_____
41. The thought of my body decay- ing after I die scares me.	_____	_____	_____	_____	_____
42. I am afraid I will never see my children grow up.	_____	_____	_____	_____	_____

Note. The fear of dying scale consists of statements 1, 13, 19, 22, 30 and 37. The fear of the dead scale consists of statements 2, 9, 14, 18, 24 and 31. The fear of being destroyed scale consists of statements 3, 15, 23 and 38. The fear for significant others scale consists of statements 4, 10, 17, 25, 32 and 39. The fear of the unknown scale consists of statements 5, 16, 26, 33 and 40. The fear of conscious death scale consists of statements 6, 12, 21, 27 and 34. The fear for the body after death scale consists of statements 7, 11, 20, 28, 36 and 41. The fear of premature death scale consists of statements 8, 29, 35

and 42. Responses are coded from 1 (for strongly disagree) through 5 (for strongly agree). Statements 3, 9, 16, 25 and 28 are coded in reverse (5=1, 4=2, 3=3, 2=4, 1=5).

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APPENDIX D

ULTIMATE VALUES TYPOLOGY

Subject Number _____ Date _____

DIRECTIONS: Each of the six situations described below sometimes happen to people. Read the situations and imagine that they are happening to you. Circle the one appropriate response to each question that best indicates how you feel or think. There are no right or wrong answers. Do not spend too much time on any one question, but make certain to respond to each one. It will take 10 minutes or so to finish.

1. You have just visited your doctor and he has told you that you have less than a year to live. He has also told you that your disease is incurable. Which of the following statements comes closest to expressing your reaction?
 - a. It will all work out for the best somehow.
 - b. No one should question the goodness of God's decision about death.
 - c. There is nothing I can do about it so I will continue as before.
 - d. I am angry and bitter at this twist of fate.
 - e. I have had a full life and am thankful for that.
 - f. Death is painful, but it is not the end of me.
 - g. I cannot answer this question.
 - h. None of the above.

2. Your son is very likely to be drafted and will be going into a dangerous combat area. Which of the following statements reflect your reaction?
 - a. Somehow it will all work out.
 - b. If God wants it to happen it must be all right.
 - c. This happens to lots of people, you learn to accept it.
 - d. The lottery system is unjust since it does not take individual situations into consideration.
 - e. He has been a good son and we are thankful for that.
 - f. I cannot answer this question.
 - g. None of the above.

3. You and your husband have been expecting word of a promotion for several weeks. One day it comes through. Which of the following best reflects your reaction to this good news?
- a. Good things usually happen to those who wait their turn.
 - b. God has been good to me and my family.
 - c. These things can go either way, this time it was good.
 - d. This is a surprise and I am going to enjoy it.
 - e. I am grateful to my boss for the promotion.
 - f. This is a good thing, but my religion tells me my life would have been O.K.
 - g. I cannot answer this question.
 - h. None of the above.
4. Imagine that one of your parents is dying a slow and painful death and try to figure out for yourself if there is anything that will enable you to understand the meaning of such a tragedy. Which, if any, of the following statements best expresses your state of mind in this situation?
- a. They are in pain now, but they will be peaceful soon.
 - b. Everything that happens is God's will and cannot be bad.
 - c. There is nothing to do but wait for the end.
 - d. This waiting is inhuman for them, I hope it ends soon.
 - e. We can at least be thankful for the good life we have had together.
 - f. This is tragic, but death is not the ultimate end for us.
 - g. I cannot answer this question.
 - h. None of the above.
5. Imagine that you have just had a child and that the doctor has informed you that it will be mentally retarded. Which of the following responses comes closest to your own feelings about this situation?
- a. We will try to take care of this child, but it may have to be put in an institution; either way it will all work out.
 - b. God had his own reasons for sending this child to us.
 - c. We must learn to accept this situation.
 - d. I love the baby, but why me?
 - e. I'm just plain glad to have the child here.

- f. God has sent us a heavy cross to bear and a special child to love.
 - g. I cannot answer this question.
 - h. None of the above.
6. Almost every year hurricanes level homes, flood towns, destroy property, and take human lives. How can we make any sense out of such disasters which happen, apparently, by chance? Which of the following statements best describes your answer?
- a. We can never really understand these things, but they usually have some unexpected good effect.
 - b. We cannot know the reasons, but God knows them.
 - c. We cannot know why these occur and we have to learn to live with that fact.
 - d. The government is responsible for seeing that these disasters do as little harm as possible.
 - e. I am grateful that I don't live in a hurricane area.
 - f. I am not able to explain why these things happen, but I still believe in God's love.
 - g. I cannot answer this question.
 - h. None of the above.

APPENDIX E

DEATH EDUCATION PROGRAM

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APPENDIX E

DEATH EDUCATION PROGRAM

SESSION 1

The death education program consists of five sessions utilizing audio-visual experiences of death followed by small group guided discussions. The program is aimed at fostering positive attitudes toward death and decreasing death anxiety.

LEARNING OBJECTIVES

1. To stimulate exploration of the concept of death.
2. To encourage examination of feelings and beliefs about the dying process and death.
3. To reduce anxieties about death.
4. To foster positive attitudes toward death.

ACTIVITIES

Session 1

30 minute filmstrip and cassette, Gramp: A Man Ages and Dies, followed by group discussion.

Session 2

12 minute audio-cassette, Facing Death with the Patient: An On Going Contract, followed by an 18 minute group discussion, and the first 15 minutes of a taped interview with Karen McArdle followed by group discussion.

Session 3

40 minute taped interview with Karen McArdle followed by a 20 minute group discussion.

Session 4

40 minute segment of the film, Death, followed by a 20 minute group discussion.

Session 5

30 minute audio-cassette, Conversation With a Dying Friend, followed by a 30 minute group discussion.

INTRODUCTION TO "GRAMP: A MAN AGES AND DIES"

On February 11, 1974, my grandfather, Frank Tugend, 81 years of age and of dubiously sound mind--but certainly of sound body--removed his false teeth and announced that he was no longer going to eat or drink.

Three weeks later to the day, he died.

His death brought to a close a 3 year ordeal--and a 3 year documentation--of gradual, but finally total, deterioration. Through camera and tape machine, we recorded Gramp's involvement with the curse that is described as senility, hardening of the arteries, or generalized arteriosclerosis. In real life it translates into standing naked in front of the picture window or "talking" to a giant red rabbit that lives in the refrigerator or being unable to control one's bowels.

Our experience was not unique; statistics show that three million other American families are experiencing similar problems. We wanted to share our experience with these families, for we're sure most of them are as unprepared for the experience as we were.

For this reason, it was important that we include in Gramp the difficult and unpleasant times, resisting a "sugar coating" of the story that may have made the book and this filmstrip easier to view but, at the same time, misleading.

While Gramp was difficult to care for at times, he never lost the fun-loving, humorous personality that had captivated us for as long as we could remember. The Tugend house still rang with laughter when Gramp handed his false teeth to a dinner guest and asked, "Will you butter these, please?" Even when Gramp was unable to dress himself, he was still capable of loosening all the screws on a doorknob just enough to leave one of us stuck in a bedroom with a doorknob in our hands.

Whether or not to institutionalize Gramp was a constant concern, and we weighed the benefits and detriments

from both Gramp's and the family's position. Yet knowing how Gramp had lived his life as a free, independent person, we resolved to keep Gramp with us as long as physically possible.

Undoubtedly much of our care for Gramp evolved through trial and error, and Gramp always seemed two steps ahead of our cleanup operations. Yet we felt that the love we could give Gramp in his own environment outweighed the efficient but impersonal attention Gramp would have found at an institution.

Eventually, we had to decide in the last 3 weeks whether or not to have Gramp hospitalized to be sustained by intravenous tubes. But after he had made it clear that he wanted to die, we chose to let him die at home with some dignity intact.

Following the publication of Gramp, we spoke with and received letters from hundreds of people. A few questions were consistently asked, such as "When did you decide to photograph Gramp?"

We never did "decide" to take pictures, since we have always photographed our family. Because Mark and I are both professional photographers, a camera is usually within reach at either of our homes; and often, one of us will squeeze off a few shots. We photographed before Gramp became senile, and we continue to photograph our lives.

We really began photographing Gramp's condition, however, when he required "baby-sitting." Whenever Mark or I watched him, we photographed him as a way to pass the time. Gramp never minded the camera; long after he had forgotten who we were, he recognized the person with a camera as a friend, and he would stay close to whomever had the camera.

Others asked how the experience had affected Hillary, Mark's 4 year old daughter, who was with Gramp up until the day he died. Following Gramp's death, we kept a wary eye on Hillary, wondering if the experience had caused her any harm. Today she shows a tolerance and acceptance of aging and death that is enviable to any who had such matters treated as mysterious and forbidden during their own childhoods.

During my childhood, I remember making the long drive from my home in Indiana to Pennsylvania following the death of a relative. I remained at the dead man's home, kneeling on a sofa and peering out the window, wondering

where all those sombre, dressed-in-black people were going and why I was left behind.

The shroud of death grew thicker when my father died of cancer. At the age of twelve, due to hospital regulations, I was prevented from visiting my father's room. Whatever happened in that room was left for my imagination to decide.

Most Americans, especially young people, have never witnessed death. They've been taught by society to deal with death through rejection and fear.

It is my hope that our family's experience with old age and death can help erase some of the unknowns for the viewer and contribute to a better understanding and acceptance of death and, therefore, the life process.

SYNOPSIS OF "GRAMP: A MAN AGES AND DIES"

Gramp is the story of a family's feelings and experiences while caring for its oldest member through the last years of his life and through the moments of his death. It is told as a first-person narrative, with flashbacks and original photographs by Dan Jury, one of the grandsons.

The program opens with a brief introduction by Dan Jury, telling of his family's conviction to take care of his grandfather themselves so that Mr. Tugend could have a death with dignity.

After the introduction, a flashback sequence shows Gramp and his wife, Nan, reminiscing as they look through a photograph album. This gives the viewer a sense of Gramp's character before the effects of senility started to change him. The narrator recounts his "growing-up years" and the joyous moments he and his two brothers spent each summer at his grandparents' home. As young adults, two of the boys chose to live nearby their grandparents.

The program then details the changes the family began to notice in Mr. Tugend's behavior. For example, he stopped going to a favorite place; he gave up driving; and he had trouble recognizing people, even members of his own family.

Gramp's physical deterioration also became apparent, and soon the family shared the many duties of taking care of their grandfather. Then the program tells how the family's doctor confirmed what they had suspected: Gramp was suffering from progressive senility; he would become more and

more difficult to care for. The family rejected the option of sending their grandfather to a nursing home.

The program then goes on to portray the family's experiences as Gramp declined. The narrative and flashbacks focus not only on events but on the changing feelings of different family members through this experience.

The Tugends and their doctor knew that Gramp was accepting the fact of his impending death when he took out his false teeth and declared he would not need them anymore. The family wanted to let Gramp die with dignity in the place he knew best.

Finally, Dan Jury's narrative recalls how he felt at his grandfather's death--not relief, but a "tinge of emptiness" and, most of all, "an enormous amount of respect" for his grandfather.

DISCUSSION QUESTIONS FOR "GRAMP: A MAN AGES AND DIES"

1. Nan, Gramp's wife, told her family that she hoped and prayed that she wouldn't become senile due to arteriosclerosis like Gramp; and that the Lord would take her before she became a burden to somebody else. Do you have any similar concerns about yourself and/or loved ones?
2. Gramp's only son, Lieutenant Frank Williams, was killed in a plane crash. After hearing of the accident, Gramp's wavy chestnut-colored hair turned prematurely white. For twenty-five years after that day, if anyone talked about "Buddy" in Gramp's presence, he would silently walk out of the room. Have you ever experienced the loss of a family member or close friend?

If yes, how did you respond?

If no, how do you anticipate yourself responding to the eventual death of a family member or friend?

3. In the film you saw previously and in this filmstrip, the family participated in funeral rites. What are your own personal feelings and reactions to funerals?
4. Did this close up view of aging, senility, and death make you more or less sympathetic to the needs, wishes, and fears of aging people? Could you possibly see yourself in Gramp's position? How would you want to be treated?

5. How did the Tugends' experience taking care of Gramp and watching him move toward death help them deal with and accept his death? Do you think it may have helped them prepare for their own death? Did watching this filmstrip give you a little understanding of the process of dying?
6. Did Gramp manage to die with dignity? Is it possible to die with dignity?

APPENDIX E

DEATH EDUCATION PROGRAM

SESSION 2

SYNOPSIS OF "FACING DEATH WITH THE PATIENT: AN ON-GOING CONTRACT"

Dr. Hunt discusses some of the issues associated with the treatment of the dying patient. Beginning with five general principles of patient care that have been of help to him he proposes the idea of a contract between the physician and his patient. This contract is characterized by mutual respect, trust and openness. Thus the doctor can be more comfortable in the relationship, while the patient is allowed some control and independence concerning his treatment and the course of his dying trajectory.

Dr. Hunt shares some of his personal reactions to death and dying with the audience and describes as well how his personal philosophy of life and death has influenced the care he has extended to his own dying patients.

DISCUSSION QUESTIONS FOR "FACING DEATH WITH THE PATIENT: AN ON-GOING CONTRACT"

1. Have you ever attended to the care of a dying patient? How do you think it would feel to tell a patient that he is going to die? How do you think you would be able to deal with the family of a dying or deceased person?
2. Do you think that most dying patients are aware of the seriousness of their illness? Would you personally like to be informed with candor about the seriousness of your illness? Do you think there might be serious difficulties created if you were not fully informed about the nature of your illness?
3. Have you ever believed you were subject to a dying person's hostility or envy?
4. Do you think you would try to avoid the direct questions a dying patient asked you? Why?

SYNOPSIS OF INTERVIEW WITH KAREN McARDLE

Ms. McArdle, for the last three years the Director of the St. Theresa Hospital Hospice Program, talks about her past and recent experiences as a nurse dealing with dying patients and their families. She speaks about death being a natural part of life, the variety of ways in which people deal with death, the overcoming of early fears of dying, the preparation a patient makes for death with the help of family and hospital staff and the importance of initial attitudes formed early in a nurse's training. Her use of case study material is especially helpful.

DISCUSSION QUESTIONS FOR INTERVIEW WITH KAREN McARDLE

1. Do you think you have a tendency to avoid situations that evoke thoughts of death?
2. What do you think your feelings and attitudes are towards death right now?
3. How have your reactions and feelings toward death changed over the years? What has influenced these changes?
4. Do you think you have accepted death as a natural process--an unavoidable, and not-to-be feared event?
5. Would you consider donating your body to science or a specific body part to a needy beneficiary?
6. What do you think will happen to your body after you die?

APPENDIX E

DEATH EDUCATION PROGRAM

SESSION 3

DISCUSSION QUESTIONS FOR INTERVIEW WITH KAREN McARDLE

1. What would go into you being well prepared for your death or the death of a loved one? Are you currently prepared.
2. If you had a choice, at what age and under what circumstances would you prefer to die? Why?
3. Would you like to have time before you die to deal with unfinished business or would you prefer to die suddenly?
4. If you or your loved ones suffer during the dying process, how do you think you will cope with it?
5. Do you think your religious beliefs will assist you with your dying and the death of loved ones and patients?
6. Do you have any specific concerns about death that you would like to talk about?
7. Have you experienced the death of a family member, friend, or patient? Would you describe the experience?
8. Have you ever been scared around the dying?
9. Do you think you would get depressed working with dying adults or children and their families?

APPENDIX E

DEATH EDUCATION PROGRAM

SESSION 4

SNYPOSIS OF "DEATH"

Death is filmed in Calvary Hospital, New York City, and dramatically depicts the isolation, as well as physical and emotional pain of the terminally ill while the staff ponders the best way to care for the dying patients. The film elicits strong emotions about the impersonal ways in which the terminal patients are approached. The very human aspects of the dying patient's recollections are presented. Care of the body, wrapping, the morgue, and the funeral director are also shown.

DISCUSSION QUESTIONS FOR "DEATH"

1. In the film the nurses prepared a body after death. Have you had this experience? What were your reactions? If you have not had this experience, would you anticipate any difficulties in preparing a body after death?
2. The physician stated that you can't start living until you personally solve the problem of dying. He noted that most of us will suffer in the process of dying. What are your reactions to this?
3. Albro expressed regret for the things he had not accomplished in life. Do you think this might happen to you or any of your loved ones?
4. Albro experienced a great deal of pain in the process of dying from cancer. He spoke to his family about it. He asked the physicians to give him something to relieve the pain. He prayed to the Lord to take the pain from his body. Do you see yourself or a loved one suffering in this manner at some time in the future? If you had to provide nursing care for someone like Albro, what would be your feelings and reactions? How would you comfort him?

5. In the filmstrip, "Gramps," Gramp died in his home while being cared for by family members. Gramp disliked being a burden on his family and decided to stop eating which resulted in his death. In this film, Albro dies in the impersonal environment of the hospital. At one point, Albro complains that the nurses don't pay any attention to him and that perhaps they don't realize how sick he really is. Do you have any concerns about how you or loved ones will experience the dying process, and how you or loved ones will be cared for during this time?

APPENDIX E

DEATH EDUCATION PROGRAM

SESSION 5

SYNOPSIS OF "CONVERSATION WITH A DYING FRIEND"

What is it like to be dying? Connie Goldman and her friend Margie talk one afternoon about Margie's impending death. Margie shares penetrating and often anxiety-provoking glimpses into the world of one who numbers herself among the dying. She does not discuss her dying in abstract terms, but rather by refusing to over-intellectualize her thoughts and feelings she compels people to follow her to a richer, fuller understanding of their finite selves.

Everyone knows he/she will die, but for Margie death is her companion in life and similarly, life is the thread that runs through her dying. Margie talks about what happens when disease defines, particularizes and limits one's lifespan. She talks of how the imminence of death thrusts a new identity onto the individual. Being "of the dying," she says, irrevocably alters your self-concept--both as a result of the adjustments the dying person must make, and because of the perceived differences in other's treatment of you. Margie believes these differences in perception are the result of others' subconscious addition of your name to their death list. For them, you are identified among the dead. Consequently, relationships are strained, social and emotional barricades spring up and the dying person is regarded as an excessively fragile object. Margie insists the dying are not so fragile and challenges this view by suggesting that what is meant to be protective of the dying may actually be a psychological barricade erected to protect the non-dying. Indeed, Margie observes that she is often placed in the curious, frustrating position of having to protect others from her dying.

Margie places dying in a developmental schema. Just as adolescence must precede more satisfying adult roles, so too, one must grow into the enriched reality of the dying. Though this growth must largely come from within, family members, friends, and those in the care-giving professions

can also be of immeasurable help. The path is often long, however. The progression of the disease, repeated medical intervention, and the gradual deterioration or mutilation of the body as physicians try to halt the disease, all must be dealt with. Yet at the same time, Margie communicates strongly the peace, strength and assurance that resides in one who has come to terms with her own death.

Margie insists that coming to terms with death is not an end in itself and the greatest mistake people make undergoing this painful process is the assumption that one's identity dies to the degree that it obscures life and living. In this connection she chides sociologists, psychologists and others who overfeel, overtalk, and overkill death.

DISCUSSION QUESTIONS FOR "CONVERSATION WITH A DYING FRIEND"

1. Connie and Margie agreed that for most people one's death is off in the future, it is a never never land. How do you conceive of your death?
2. Margie does not believe in a life after death. What do you think will happen to you after death? Do you have any concern or fears about this?
3. Margie was shaken when she had to have a mastectomy, and later she was terrified upon discovering that the cancer had metastasized. She didn't want to become disfigured and dependent upon others. Do you feel this could happen to you or any of your loved ones? Do you have any concern or fears about this?
4. Margie stated that preparation for dying means preparation for living while you are living and not only acceptance of death. What do you think she meant by this? Do you agree or disagree? How have you prepared for your own death and the death of loved ones?
5. In the previously shown film and filmstrip, an elderly grandparent died. The families reacted with sorrow but felt their loved one had lived a long and worthwhile life. In this tape, Margie is only 46 years old and her family is not prepared for her death. Premature death appears to be much more difficult for us to accept. Have you ever considered the possibility of yourself or a loved one dying prematurely? What are your thoughts about this?

6. Margie noted that people treat her differently now that she is dying. They avoid the open discussion of her death either in an attempt to protect her or protect themselves. How would you respond when talking to a dying individual? Would it make a difference if the dying person was a patient or a loved one?

APPROVAL SHEET

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

4-18-83
Date

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